

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 23 Filing 110 3/11/69 kk										Item 23 Filing 110 3/11/69 kk									
03995										03988									
1. DECEASED-NAME (Type or Print)										2a. DATE KNOWN OF ESTI- DEATH MATED									
HARRY JOHN AREE ABEL										Month Day Year 5 89 3:25M									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Male		white		April 25, 1896		72 YRS.		10 10				March 5, 1969		3:25M					
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH							
New York City				USA								Montgomery Md.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring				14000 Castle Blvd				Pressman				Gv't PrintOff.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland				Montgomery				Silver Spring						14000 Castle Blvd. Apt. 802					
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last													
Henry Abel						Mary Barclay													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service)						16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS							
yes WW1 Navy								wife											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary embolus, bilateral,</u> <u>8120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>due to auto accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year 5 2-25 69 PM				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <u>deceased, driving alone in auto which another car struck</u>									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Street</u>				21f. LOCATION Street or R.F.D. No. City or Town County State <u>Greentree Rd. Bethesda Montgomery Md.</u>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Belden R. Reap</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED							
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						ADDRESS <u>Street city, town or county</u> <u>March 5, 1969</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)									
Burial				3-8-69		Gate of Heaven				Silver Spring, Md.									
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>7557-Wisconsin Ave., Bethesda, Md.</u>										25a. REC'D BY REGISTRAR DATE <u>MAR 6 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

7703

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YJC 58

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03996		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03989	
Item 6 Film 6411 4/11/69 kk					
1. DECEASED-NAME (Type or print)			2a. DATE OF DEATH		2b. HOUR -
First Middle Last GUNTHER S ADAMS			Month Day Year Mar 31 69		12 25 M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS
MALE	White	Feb. 18, 1896		73 1/2 YRS.	HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH		
MARYLAND	U.S.		Montgomery Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING, MD.	SYLVAN HAVEN HEALTH CARE CENTER				PLASTERER
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
MD.	BALTO.	BALTIMORE		3203 N. Charles ST.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
First Middle Last KARL ADAMS	First Middle Last HARRIET W. BECK WITH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT		Address	
Yes	215-16-1530	GEO. TRUDITHOBARGE		322 KENDRICK AVE. BALTO. MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion 1420 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Prostate DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Oct 4, 1968, to Mar 31, 1969, that (I) (we) lost saw the deceased alive on Mar 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert T. Thibodeau		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-31-69	
22d. PHYSICIAN'S NAME (Type) DR. R. THIBODEAU		22e. ADDRESS Rockville 20852			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)	(County) (State)
Burial	4-2-1969	Parkwood Cemetery		Parkville	Balto. Md
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
LASSA HNN FUN. HOME - BALTO. MD.		BLAIR RD		APR 8 1969	Charles Judge

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STATE OF TEXAS

NO. 10000

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STATE OF TEXAS



STATE OF TEXAS

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03997

CERTIFICATE OF DEATH

03990

1. DECEASED-NAME (Type or print) <i>Vincent Edmond Adams</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>24</i> Year <i>69</i>			2b. HOUR <i>7:20</i> M					
3. SEX <i>MALE</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH <i>4-18-05</i>		6. AGE (In years last birthday) <i>63</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			Md.		
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington San + Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Printer</i>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>7810 Garland Ave</i>			
14. FATHER'S NAME First <i>Fred</i> Middle <i>Adams</i> Last <i>Adams</i>			15. MOTHER'S MAIDEN NAME First <i>Mattie</i> Middle <i>Wheeler</i> Last <i>Wheeler</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>Chart</i>		Address					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>meningitis, acute.</i>			
7123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia + atelectasis</i>	
		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe Osteoporosis 2nd stage + Rheumatoid Arthritis</i>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>2-17</i> , 1969, to <i>3-23</i> , 1969, that (I) (we) last saw the deceased alive on <i>3-23</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>George M. Grames M.D.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <i>George M. Grames</i>				22e. ADDRESS <i>7400 Carroll Ave., Takoma Park, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>March 27-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Packwood Cemetery, Silver Spring, Md.</i>		23d. LOCATION (City or Town) (County) (State) <i>MD</i>	
24. FUNERAL DIRECTOR <i>Arthur Waters</i>		ADDRESS <i>254 Carroll St. 7</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 27 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Richard E. Gudge</i>	

11-22-64

CONFIDENTIAL

78280



TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[illegible text follows]

X

[illegible text follows]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
JACQUELINE M ADDISON						Month Day Year			12:30		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR		
Female	Negro	11/18/68	4 mos YRS.	MONTHS	DAYS	Month Day Year			12:30		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH		
B thesda Md.			USA			NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hospital			minor					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Montgomery			Rockville Md			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
Larry A			Addison			Delorse V. Watson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
none						father Larry			102 Dawson Ave. Rockville Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Congenital heart disease manifest											
746.0 DUE TO, OR AS A CONSEQUENCE OF											
by left lower pulmonary artery											
DUE TO, OR AS A CONSEQUENCE OF											
communication with left atrium											
PART 2. OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			M.D.			DEPUTY MEDICAL EXAMINER			3/26/1969		
Belden R. Reap M.D.						ADDRESS (Street, City, Town, or County)					
23a. BURIAL, CREMATION, or REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			3-29-69			Ash Memorial			Sandy Spring Montg Md		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Robert L. Snowden			Rockville Md			APR 3 1969			Charles Judge		

32660

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) LEIGH C. ALLNUTT			2a. DATE OF DEATH Month MARCH Day 1 Year 1969			2b. HOUR 3:40 P.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH 9-16-1882		6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SILVER MANOR HEALTH CARE CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. 8805 WALNUT HILL RD.		13b. CITY OR TOWN GAITHERSBURG		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8805 WALNUT HILL RD.			
14. FATHER'S NAME G. W. CHOATE		15. MOTHER'S MAIDEN NAME Annie W. Finley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. 213-504-146		17. INFORMANT MRS. T. S. MASON, JR. Address 8805 WALNUT HILL RD. GAITHERSBURG, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DIS. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from FEB 7 , 19 69 , to MARCH 1 , 19 69 , that (I) (we) lost saw the deceased alive on FEB 26 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert T. Thibadeau				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED MAR 1-69			
22d. PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU				22e. ADDRESS ROCKVILLE MD 20852					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/4/69		23c. NAME OF CEMETERY OR CREMATORY Rockville		23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery, Md.			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				24b. CITY Rockville		24c. STATE Md.		24d. RECEIVED BY REGISTRAR MAR 4 1969	
25b. REGISTRAR'S SIGNATURE [Signature]									

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FOR STATE
HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) <i>First Middle Last</i> <i>Gilford Amick</i>			2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month Day Year <i>March 15 1969</i>		2b. HOUR <i>6:30 PM</i>					
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>9/27/14</i>	6. AGE (In years last birthday) <i>54</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year <i>March 15 1969</i>		2d. HOUR <i>6:30 PM</i>		
7a. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Engineer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT&T CO.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Mont. Charles</i>		13c. CITY OR TOWN <i>Westport</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5304-Westport Rd.</i>	
14. FATHER'S NAME <i>First Middle Last</i> <i>Henry Amick</i>			15. MOTHER'S MAIDEN NAME <i>First Middle Last</i> <i>Lola Odell</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. <i>236-05-4443</i>		17. INFORMANT <i>Luby Amick</i>		ADDRESS <i>same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Old myocardial Infarct</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>March 16, 1969</i>				
EXAMINER'S NAME (Type) <i>JOHN G. BALL, M.D.</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
			ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>MARCH 18, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <i>RAINELLE, WEST VIRGINIA</i>				
24. FUNERAL DIRECTOR <i>William M. Hyson</i>			ADDRESS <i>WASH., D.C.</i>			25a. REC'D BY REGISTRAR DATE <i>MAR 18 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
HYSONG'S FUNERAL HOME-1300 -N STREET, N.W.										

HEALTH DEPT
STATE

1900

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DIVISION OF HEALTH, NEW YORK STATE, DEPARTMENT OF HEALTH

1900

A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 11-19

04001		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03994	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <u>Albert S. Anderson</u>			2a. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1969</u>			2b. HOUR <u>PM</u>	
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>11-13-99</u>		6. AGE (In years lost birthday) <u>69</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Illinois</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>Rockville</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Potomac Valley Nursing Home</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>	
13a. USUAL RESIDENCE (Where deceased admission) STATE <u>Md.</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Rockville</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <u>Unknown</u>		15. MOTHER'S MAIDEN NAME <u>Unknown</u>		13e. STREET AND NUMBER <u>503 Goldsboro Drive</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>319-03-9427</u>		17. INFORMANT Address <u>Mrs. Frank Leone-same item # 13-Daughter</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC BRAIN SYNDROME</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PARKINSON'S DISEASE</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>CHRONIC URINARY TRACT INFECTION</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 15, 1969</u> , to <u>MAR 5, 1969</u> , that (I) (we) last saw the deceased alive on <u>MAR 3, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert C. Daddario</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>MAR 5 1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>ROBERT C. DADDARIO</u>				22e. ADDRESS <u>5413 CEDAR LANE BETHESDA</u>			
23a. BURIAL, CREMATION, or other disposition <u>Burial</u> (city)		23b. DATE <u>3/8/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> ADDRESS <u>Funeral Home 1331 Rock Pike</u> <u>Rockville, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 10 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04002		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03995			
Item 1 Film 410 3/27/69 kk									
1. DECEASED-NAME (Type or print)				First Middle Last		2a. DATE OF DEATH		2b. HOUR	
JAMES MI H. ANDERSON						Month Day Year MARCH 14 1969		5:55 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE		WHITE		7/3/15		53 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
VA.		U. S. A.				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		HOLY CROSS		Montg. Co. Employee					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		MONTGOMERY		POOLESVILLE					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Henry Anderson		Susie Latten							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no		218-30-3863		Mrs. Mae Anderson		Poolesville Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Coronary artery</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF <u>Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis obliterans</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Repeated Surgery for b/</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/16, 1968</u> , to <u>3/14, 1969</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<u>W. F. Marcus</u>						3/14/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
WILLIAM MARCUS, M.D.		10620 Georgia Ave., Sil. Spr., Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/17/69		Monacacy		Beallsville Montg Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William B. Hilton		Beallsville, Md.		MAR 18 1969		Charles Judge			

3020

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First GEORGE			Middle M.		Last ARROWSMITH		2a. DATE OF DEATH Month March , Day 17 , Year 1969		2b. HOUR 7A M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH Aug. 28, 1886			6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) ST. LOUIS, MO.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.									
10. CITY OR TOWN OF DEATH CHEVY CHASE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7201 MEADOW LANE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY ARMY OFFICER						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE		13d. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7201 MEADOW LANE						
14. FATHER'S NAME First GEORGE			Middle -			Last ARROWSMITH			15. MOTHER'S MAIDEN NAME First ROSETTA			Middle -		Last CHARTRAND	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES			(If yes give war or dates of service) 1908-1946		16b. SOCIAL SECURITY NO. 220-44-5825		17. INFORMANT Address ANNE R. ARROWSMITH, 7201 MEADOW LANE, CH. CH., MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right middle cerebral thrombosis 4329 DUE TO, OR AS A CONSEQUENCE OF (b) cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) generalized arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days years years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) arteriosclerotic heart disease															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 5-15 , 19 66 , to 3-17 , 19 69 , that (I) (we) last saw the deceased alive on 3-16 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Oscar Mann M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-17-69					
22d. PHYSICIAN'S NAME (Type) OSCAR MANN M.D.		22e. ADDRESS 2141 K ST. WASH DC													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/19/1969		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.				23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA							
24. FUNERAL DIRECTOR ADDRESS JOS. BAWLER'S SONS, 5130 WIS. AVE, WASH, D.C.						25a. RECD BY REGISTRAR DATE MAR 20 1969		25b. REGISTRAR'S SIGNATURE [Signature]							

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UNITED STATES DEPARTMENT OF THE INTERIOR

OFFICE OF THE SECRETARY

WASHINGTON, D.C.



[Faint handwritten text, possibly a signature or initials]

RECEIVED

DEPARTMENT OF THE INTERIOR

WASHINGTON

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03997

VR A15ME (5)
10M REV. 1/68

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3-Page 5 may be retained for your files.

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04005

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03998

1. DECEASED-NAME (Type or Print) <u>William Edwin Baker</u>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <u>March</u> Day <u>21</u> Year <u>1969</u>			2b. HOUR <u>7:00</u> M				
3. SEX <u>M.</u>	4. RACE <u>W.</u>	5. DATE OF BIRTH <u>July 27, 1916</u>	6. AGE (In years last birthday) <u>52</u> YRS.	IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>	IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u>	2c. DATE PRONOUNCED DEAD Month <u>March</u> Day <u>22</u> Year <u>1969</u>			2d. HOUR <u>4:00</u> M	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.				
10. CITY OR TOWN OF DEATH <u>Rockville</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>504 Beall Ave.</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Building Inspector</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Montg. County</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>			13b. COUNTY <u>Montgomery</u>			13c. CITY OR TOWN <u>Rockville</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <u>Jessie</u> Middle <u> </u> Last <u>Baker</u>			15. MOTHER'S MAIDEN NAME First <u> </u> Middle <u> </u> Last <u> </u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>				
16b. SOCIAL SECURITY NO. <u>5710</u>			17. INFORMANT <u>Perry Baker-Brother-</u>			ADDRESS <u>Washington, D.C. 4117 W.St. N.W.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro Intestinal Hemorrhage-Massive</u> <u>5710</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Esophageal Varices -</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cirrhosis of Liver (Laennec's)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>Months.</u> <u>years.</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u> </u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>John G. Ball</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>March 23, 1969</u>				
EXAMINER'S NAME (Type) <u>John G. Ball-Bethesda, Maryland</u>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
ADDRESS (Street, city, town, or county) <u>7936 Old Georgetown Rd.</u>										
23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		23b. DATE <u>3/27/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>			
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>				ADDRESS <u>1331 Rock. Pike</u>			25a. REC'D BY REGISTRAR <u>MAR 26 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Francis Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04006

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03999

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Baby Girl Boy			2a. DATE OF DEATH Month Day Year March 14 1969			2b. HOUR 6 35 P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 14, 1969		6. AGE (In years last birthday) YRS. MONTHS DAYS 9 3 6			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12200 Braxfield Court	
14. FATHER'S NAME First Middle Last Vernon Allen Ball			15. MOTHER'S MAIDEN NAME First Middle Last Mickey Lee Sisler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Mother					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE MARVIN MOIVES				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/14/69	
22d. PHYSICIAN'S NAME (Type) MARVIN MOIVES M.D.				22e. ADDRESS 9801 G.A. Ave Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/20/69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				ADDRESS 1331 Rock Pike Rockville, Md.		25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

80040

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) IVA			First Middle Last P. BALLARD			2a. DATE OF DEATH Month 3 Day 8 Year 1969		2b. HOUR 10 a M	
3. SEX F		4. RACE CAU		5. DATE OF BIRTH 3/23/14		6. AGE (In years last birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH CHEVY CHASE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5502 MONTGOMERY ST.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALES GIRL		12b. KIND OF BUSINESS OR INDUSTRY CONCESSION	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WASH.D.C.			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3601 CONN. AVE.N.W.#306		
14. FATHER'S NAME First Middle Last ISSAC FRED PHOEBUS			15. MOTHER'S MAIDEN NAME First Middle Last SADDIE GREEN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 218-16-8889		17. INFORMANT Address JAMES TAYLOR 5502 MONTGOMERY ST.MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Brain damage.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral vascular blood.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4379</u> APPROXIMATE INTERVAL BETWEEN ONSET AND ONATH <u>recent</u> <u>8 mos</u> <u>understand</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> , 19 <u>68</u> , to <u>3/8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/8</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stanley A Schwartz</u> MD					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>3/8/69</u>	
22d. PHYSICIAN'S NAME (Type) STANLEY SCHWARTZ M.D.					22e. ADDRESS 2400 "H" ST. N.W. WASH. D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-11-69		23c. NAME OF CEMETERY OR CREMATORY Monhain Cemetery		23d. LOCATION (City or Town) (County) (State) Princess Anne Maryland			
24. FUNERAL DIRECTOR Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md					25a. REC'D BY REGISTRAR MAR 12 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Smith</u>		

04007

DEPARTMENT OF DEATH

MANHATTAN DISTRICT OF NEW YORK

100-1000

NAME OF DECEASED: JAMES J. JONES

DATE OF DEATH: 11-11-1978

PLACE OF DEATH: NEW YORK, N.Y.

CAUSE OF DEATH: HEART DISEASE

AGE: 45

SEX: M

RACE: W

11-11-1978 JAMES J. JONES

NEW YORK, N.Y.

HEART DISEASE

45

M

W

NEW YORK, N.Y.

HEART DISEASE

45

M

W

NEW YORK, N.Y.

HEART DISEASE

45

M

W

04008

CERTIFICATE OF DEATH

04001

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>9510 Hale Place</i>	
3. NAME OF DECEASED (Type or print) <i>ISADORE</i>		4. DATE OF DEATH Month <i>March</i> Day <i>24</i> Year <i>1969</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/10/16</i>
9. AGE (In years lost birthday) <i>52</i> yrs.		10. BIRTHPLACE (County & State, or foreign country) <i>Russia</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>grocery/butcher</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Itzik Barr</i>		14. MOTHER'S MAIDEN NAME <i>Ida Tarkovsky</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes W.W. 11</i>		16. SOCIAL SECURITY NO. <i>579-01-3083</i>	
17. INFORMANT <i>Daughter/ Sandra Smith, 12303 Barbara Road</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis, Acute</i> 4109 DUE TO (b) <i>Hypertensive Hx. Dis.</i> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>o.m.</i> <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 1968, to <i>Feb. 25</i> , 1969, that (I) (we) last saw the deceased alive on <i>Feb. 25</i> , 1969, and that death occurred at <i>11:15 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Isidore Shulman</i>		22b. DATE SIGNED <i>3-24-69</i>	
22c. PHYSICIAN'S NAME (Type) <i>ISIDORE SHULMAN</i>		22d. ADDRESS <i>915-19th ST. N.W. DC</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>Mar. 26, 1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mount Lebanon Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Hyattsville, Maryland</i>
24. FUNERAL DIRECTOR <i>Donald M. Stein</i>		25a. REC'D. BY REGISTRAR <i>28 1969</i>	
<i>Hebrew Memorial Funeral Home</i>		<i>St., N.W. Wash., D.C.</i>	

MEDICAL CERTIFICATION

Cleared with Dr. Reap

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04008

OFFICE OF LEAD

12401

1-27-67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04009 CERTIFICATE OF DEATH 04002									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR M	
EMMA LOUISE BARRETT						3 Month 1 Day 1969			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Negro		8/10/1880		88 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
No. Carolina		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Wheaton		Univ. Nurs. Home		School teacher					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Washington, DC								5013 Jay St., NE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Wyatt Harper			?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			none		Gracie Swinson-5013 Jay Street, NE. Daugh.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic myeloid leukemia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
				11/21, 1968, to 2/12, 1969					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> , 19 <u>68</u> , to <u>2/12</u> , 19 <u>69</u> , that we (we) last saw the deceased alive on <u>2/12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>David Morowitz, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
David Morowitz, M.D.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3-7-69		Church Cemetery		Tarboro, North Carolina			
24. FUNERAL DIRECTOR John T. Rhines Co. Funeral Home 3015 12th Street, NE., Washington, D. C.				25a. REC'D BY REGISTRAR DATE MAR 6 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Young</u>			

04009

Class English Grammar

1980

No. 10011

Unit, 10011, 10011

General Section

10011, 10011

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04010										
04003										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last ROSIE MARY BEALL					2a. DATE OF DEATH Month 3 Day 3 Year 69			2b. HOUR 10 P.M.		
3. SEX female		4. RACE white		5. DATE OF BIRTH 3-2-72		6. AGE (In years last birthday) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) White Oak, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1201 Harper Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1201 Harper Rd. Silver Spring Maryland	
14. FATHER'S NAME First Middle Last George Harper					15. MOTHER'S MAIDEN NAME First Middle Last Mary Hopkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-44-2203		17. INFORMANT Mrs. Jone Sorensen Address 1201 Harper Road Silver Spring, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4123 IMMEDIATE CAUSE (a) A.S.H.D. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from NOV , 19 63 , to 3-3 , 19 69 , that (I) (we) last saw the deceased alive on 3-3 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE D. F. Sengstack						22c. DATE SIGNED 3-3-69		22d. PHYSICIAN'S NAME (Type) G. F. Sengstack		
22e. ADDRESS 9241 Columbia Blvd. Silver Spring, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Mar. 7, 1969		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery			23d. LOCATION (City or Town) (County) (State) Forest Glen, Maryland-Mont. Cty.		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.						25a. REC'D BY REGISTRAR DATE MAR 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

01050

2010-11-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04011										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04004									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Gussie Middle None Last Bean										3 Month 24 Day 69 Year										10P M									
3. SEX Male					4. RACE White					5. DATE OF BIRTH July 24 1877					6. AGE (In years last birthday) 91 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) W. Va.					7b. CITIZEN OF WHAT COUNTRY? U.S. A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Montgomery Md.														
10. CITY OR TOWN OF DEATH Rockville					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 12701 Gould Rd					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer					12b. KIND OF BUSINESS OR INDUSTRY Farm														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.					13b. COUNTY Hampshire					13c. CITY OR TOWN Baker					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER Baker, W. Va									
14. FATHER'S NAME First Edmund Middle Bean Last					15. MOTHER'S MAIDEN NAME First Margaret Middle Evans Last																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No					16b. SOCIAL SECURITY NO. none					17. INFORMANT Marvin Bean					Address Baker, W. Va.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease																				3 yrs									
4123 DUE TO, OR AS A CONSEQUENCE OF (b)																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Arterio sclerosis																				8 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 1966, 19, to 3-24, 1969, that (I) (we) last saw the deceased alive on March 24 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE A.W. Smith M.A.										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 3-24-69														
22d. PHYSICIAN'S NAME (Type) A.W. SMITH										22e. ADDRESS 13018 GEORGIA AVE WHEATON, MD																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 3-27-69					23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery					23d. LOCATION (City or Town) Baker, West Virginia (County) (State)														
24. FUNERAL DIRECTOR Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md										25a. REC'D BY REGISTRAR DATE APR 1 1969					25b. REGISTRAR'S SIGNATURE														

71020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
30M REV. 1-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04012					04005				
Item 7 Film 410 3/14/69 kk					CERTIFICATE OF DEATH				
1. DECEASED-NAME (Type or print) <i>Yetta Becker</i>					2a. DATE OF DEATH 3 Month 5 Day 69 Year			2b. HOUR 11 ³⁰ PM	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>9/15/77</i>		6. AGE (In years last birthday) <i>91</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>ENGLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i> Md			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>CHESH.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4701 WILLARD AVE</i>	
14. FATHER'S NAME <i>Abraham Weisenberg</i>			15. MOTHER'S MAIDEN NAME <i>Unknown</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Son-in-law</i> <i>Sherry Peak</i> 4701 Willard Ave Chesh Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>485X</i> IMMEDIATE CAUSE (a) <i>Probable bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Renalized arterioclerosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2-23, 1967</i> , to <i>3-5, 1969</i> , that (I) (we) last saw the deceased alive on <i>3-5, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Abraham W. Danish MD</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-6-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>ABRAHAM W. DANISH</i>				22e. ADDRESS <i>1106 Spring St. S-S-Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>3-7-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>OSHEV SHOLOM-TALMUD TARA</i>		23d. LOCATION (City or Town) (County) (State) <i>WASHINGTON DC</i>			
24. FUNERAL DIRECTOR <i>BERNARD DANZANSKY & SONS - WASHINGTON DC</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 11 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Richard Judge</i>			

04018

STATE OF TEXAS

MAR 1 1968

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04013		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04006					
1. DECEASED-NAME (Type or print) Elizabeth		First P.		Middle Bendell		2a. DATE OF DEATH March Month 13 Day 69 Year		2b. HOUR 12 P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7/30/1890		6. AGE (In years lost birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Buyer				Dept. Store	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 199 Rollins Avenue			
14. FATHER'S NAME Thomas		First Middle Last Maloney		15. MOTHER'S MAIDEN NAME Delia		First Middle Last Hayes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or unknown) No		(If yes give war or dates of service) ---		16b. SOCIAL SECURITY NO. 078 10 6545		17. INFORMANT 1014 Welsh Dr. Daughter-Mrs. Joseph McNulty		Address Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) hypertensive cardiovascular disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (1) (this hospital) attended the deceased from Feb 12, 1958, to March 13, 1969, that (1) (we) last saw the deceased alive on Jan 17, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE G. Bowditch Hunter, Jr., M.D.		22c. DATE SIGNED March 13, 1969		22d. PHYSICIAN'S NAME (Type) G. Bowditch Hunter		22e. ADDRESS 50 W. Edmonston Drive, Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/15/69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring, Montg. Md.					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1531 Rockville Rockville, Maryland		25a. REC'D BY REGISTRAR MAR 17 1969		25b. REGISTRAR'S SIGNATURE W. Charles Judge					

51040

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04014

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04007

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF DEATH				Month	Day	Year	2b. HOUR
ALFRED			H.	BENNA	MAY 29 1969							7:30 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
MALE	WHITE	5/10/12		56 YRS	MONTHS		DAYS		MARCH 29 1969		7:50 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.		
PENNA		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		MONTGOMERY						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA				SUBURBAN				COUNSELLOR				MONT Co Schol
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?
MD				MONTGOMERY				BETHESDA				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13e. STREET AND NUMBER				
TILLMAN K				BENNA				3 Tulip Drive				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS
NAVY				WILL				WIFE FAY D BENNA				SAME
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) INTRACEREBRAL Hemorrhage											11hr	
DUE TO, OR AS A CONSEQUENCE OF												
(b) MASSIVE SKULL FRACTURE											11	
DUE TO, OR AS A CONSEQUENCE OF												
(c) Trauma from fall down stairs												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
				7:12 PM 3-29 1969				Fall down cellar stairs				
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Home				3 Tulip Drive - Bethesda, Montgomery, Md				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED				
John G. Ball								March 29, 1969				
EXAMINER'S NAME (Type)				7936 Old Georgetown Road, Bethesda, Maryland				ASSISTANT MEDICAL EXAMINER				
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
								ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				
Burial				April 1, 1969				Trinity Church Cem.				
23d. LOCATION (City or Town) (County) (State)				24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				
Bedford, Pa.				Tyson Wheeler F. H. 1331 Rockville Pike				APR 7 1969				
				Rockville, Maryland				25b. REGISTRAR'S SIGNATURE				
								Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Dewey Sampson Bennett						March 17 1969		11:50 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		Negro		1 * 21 - 14		55 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
North Carolina		Montgomery				Montgomery		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park, Md.		Washington Sanitarium		Janitor					
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Silver Spring		NO		8110 Tahona Dr. #401	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Junius N. Bennett			Lula C. Sampson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address		Silver Spring Md.		
					Helen Bennett - 8110 Tahona Dr.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory and Myocardial failure</u> 571.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute brain syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cirrhosis of Liver Advanced (Nutritional)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 56 hrs. Unknown									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>Carcinoma of Esophagus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (H) (this hospital) attended the deceased from <u>March 13</u> , 19 <u>69</u> , to <u>March 17</u> , 19 <u>69</u> , that (H) (we) last saw the deceased alive on <u>March 17</u> , 19 <u>69</u> , and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Allen H. Trauman</u> M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>March 18, 1969</u>					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS <u>8237 Georgia Ave. Silver Spring Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3-22-69		Lincoln Memorial Cemetery		Suitland, Maryland			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
<u>John T. Rhine 3015-12th St. N.E.</u>				MAR 24 1969		<u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Eileen C. Berlin</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>18</i> Year <i>69</i>			2b. HOUR <i>5⁴⁵ A</i>					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>6-29-16</i>		6. AGE (In years last birthday) <i>52</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Nurse</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8711 Maywood Ave.</i> <i>Silver Spring, Md.</i>	
14. FATHER'S NAME First <i>Reuben</i> Middle <i>Cutter</i> Last <i>Beatrice Mollie</i>			15. MOTHER'S MAIDEN NAME First <i>Beatrice Mollie</i> Middle <i>-</i> Last <i>-</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <i>089-22-5661</i>			17. INFORMANT Address <i>S.S. Lyle Berlin, Son, 8711 Maywood Ave. Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma from Pancreas</i> <i>1579</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <i>March '68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>neck node</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 15, 1965</i> , to <i>18 March 1969</i> , that (I) (we) last saw the deceased alive on <i>17 March 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Ira N. Tublin</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>March 18, 1969</i>			
22d. PHYSICIAN'S NAME (Type) <i>Ira N. Tublin, Md.</i>						22e. ADDRESS <i>800 Pershing Dr., Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/19/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Montefiore Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>L. I., N. Y.</i>					
24. FUNERAL DIRECTOR <i>Bernard Danzansky & Sons, Wash., D.C.</i>						25a. REC'D BY REGISTRAR DATE <i>MAR 20 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Young</i>			

NAME	
ADDRESS	
CITY	
STATE	
ZIP	
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TITLE	
OFFICE	
AGENCY	
PROJECT	
FUNDING	
STATUS	
COMMENTS	
APPROVAL	
REVISIONS	
DISTRIBUTION	
ARCHIVAL	
OTHER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Sylvia Cummings BETTS.			2a. DATE OF DEATH MAR Month 21 Day 1969 Year			2b. HOUR 6:10 PM			
3. SEX FEMALE		4. RACE CAUC		5. DATE OF BIRTH 11-1-09		6. AGE (In years lost birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH BROOKMONT		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6506-RIDGE DR.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) EDITOR		12b. KIND OF BUSINESS OR INDUSTRY FILM			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BROOKMONT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6506-RIDGE DR.	
14. FATHER'S NAME First Middle Last HUBREY ST. GEORGE CUMMINGS			15. MOTHER'S MAIDEN NAME First Middle Last LUCIE H. SHERWILL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown) (If yes give war or dates of service)) NO		16b. SOCIAL SECURITY NO. 579-50-5686		17. INFORMANT THOMAS I. BETTS		Address 6506-RIDGE DR.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH CAUSED BY:									
IMMEDIATE CAUSE (a) Acute myocardial infarction stat									
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease unk.									
DUE TO, OR AS A CONSEQUENCE OF (c) 									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic congestive heart failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JAN , 1969, to MAR 21 , 1969, that (II) (we) lost saw the deceased alive on MAR 20 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert S. Poole				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED MAR 21, 1969			
22d. PHYSICIAN'S NAME (Type) Robert S. Poole				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) XXX		23b. DATE 3-24-69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland Maryland			
24. FUNERAL DIRECTOR Robert A. Pumphrey 7557-Wisconsin Ave., Bethesda, Md.				25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE Charles J. Judge			

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DEPARTMENT OF HEALTH

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Name of Patient	
Address	
City	
State	
Date of Birth	
Sex	
Race	
Religion	
Occupation	
Education	
Marital Status	
Social Security Number	
Date of Admission	
Date of Discharge	
Admission Diagnosis	
Discharge Diagnosis	
Treatment	
Nursing	
Diet	
Medication	
Vital Signs	
Laboratory Tests	
X-ray	
Pathology	
Other	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR
HAROLD F. Bichsel					3		1	1969	10	58
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
male	White	July 28, 1905		63 YRS.	MONTHS		DAYS		Month	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. DATE PRONOUNCED DEAD		2d. HOUR
Ohio		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		3		1969
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET AND NUMBER		13b. COUNTY
Bethesda		Suburban Dist.		Sales manager		B.F. Goodrich		4708 Falstone Ave.		Mont.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		13f. COUNTY
Md.		Mont.		Cherry Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4708 Falstone Ave.		Mont.
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Frederick				Bichsel	Estelle				Hoppes	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
No		297-10-5718		Wife - Nellie Bichsel		- Same		PART 1. DEATH WAS CAUSED BY:		
								IMMEDIATE CAUSE (a)		
								4123		
								DUE TO, OR AS A CONSEQUENCE OF		
								Coronary Insufficiency Acute		Sudden
								(b)		
								Cardiovascular Disease		Years
								DUE TO, OR AS A CONSEQUENCE OF		
								(c)		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18)						
		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED						
JOHN G. BALL		M.D.		March 1, 1969						
EXAMINER'S NAME (Type)		BETHESDA, MONTGOMERY, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
BURIAL		MARCH 5 1969		HIGHLAND MEMORIAL PARK		ALLIANCE		OHIO		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
ROBERT A. PUMPHREY		7557 WISC. AVE BETHESDA Md.		MAR 5 1969		Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04019		CERTIFICATE OF DEATH						04012			
1. DECEASED-NAME (Type or print) Wilford						First BIVENS		Middle		Lost	
2a. DATE OF DEATH March Month 25 Day 69 Year						2b. HOUR 505P M					
3. SEX Male			4. RACE Negro			5. DATE OF BIRTH Oct. 14, 1922			6. AGE (In years last birthday) 46 YRS.		
7a. BIRTHPLACE (State or foreign country) N. Carolina			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Diet Cook			12b. KIND OF BUSINESS OR INDUSTRY Food		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D. C.			13b. COUNTY Washington			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 1252 Owen Place, N. E.			14. FATHER'S NAME First Jessie Middle Bivens Lost Lessie			15. MOTHER'S MAIDEN NAME First Lessie Middle Marshall Lost Marshall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b. SOCIAL SECURITY NO. 9373294			17. INFORMANT Washington, D. C. Address D. C.			17b. Mrs. Elaine Bivens, 1706 Hobart St. N.W.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Broncho Pneumonia											
485x DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar. 25, 1969 , to Mar. 25, 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Mar. 25, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.											
22b. SIGNATURE R. D. Gaskins						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED Mar. 27, 1969		
22d. PHYSICIAN'S NAME (Type) R. D. Gaskins, M. D.						22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, or other disposition Burial			23b. DATE 3-13-69			23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.		
24. FUNERAL DIRECTOR Latney Funeral Home ADDRESS 3831 Georgia Ave., N.W. Washington, D. C.						25a. REC'D BY REGISTRAR APR 1 1969			25b. REGISTRAR'S SIGNATURE Charles J. Jones		

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**FOR STATE
HEALTH DEPT.**

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Items 18a-22a Film 413 MARYLAND STATE DEPARTMENT OF HEALTH
6-20-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

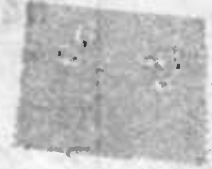
04020

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04013

1. DECEASED-NAME (Type or Print) <i>Erwin Richard Bogenrieder</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3 31 1969			2b. HOUR 5:42 P.M.			
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH 3-30-36	6. AGE (In years last birthday) 33 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>March</i> Day <i>31</i> Year <i>1969</i>			
7a. BIRTHPLACE (State or foreign country) <i>Buffalo, N. Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>1902 Valley Stream Dr.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>N.I.H. Contract Specialist</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME <i>German</i>			15. MOTHER'S MAIDEN NAME <i>Bogenrieder</i>		16. SOCIAL SECURITY NO. <i>125-28-8911</i>			17. INFORMANT <i>Martha L. Bogenrieder</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>125-28-8911</i>		17. INFORMANT <i>Martha L. Bogenrieder</i>			ADDRESS <i>Same as #13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pend. Infl.</i> <i>Encephalitis Acute Lymphocytic</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Viral infection</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>24 hrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <i>065</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John G. Bell</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>March 31, 1969</i>			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-3-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring Mont., Md.</i>			
24. FUNERAL DIRECTOR <i>Francis J. Collins</i>				ADDRESS <i>500 University Blvd. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

030



APR 7 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/1/69

MARYLAND STATE DEPARTMENT OF HEALTH																
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
04021					CERTIFICATE OF DEATH					04014						
1. DECEASED-NAME (Type or print) <i>HARRY W. BOWERS</i>					2a. DATE OF DEATH Month <i>3</i> - Day <i>15</i> - Year <i>69</i>					2b. HOUR <i>8:30 P</i>						
3. SEX <i>MALE</i>		4. RACE <i>white</i>			5. DATE OF BIRTH <i>Oct-9th-80</i>			6. AGE (In years last birthday) <i>88</i> YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN				
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.									
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Cathetersburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Free State Apts #7</i>						
14. FATHER'S NAME First <i>John</i> Middle <i>Bowers</i> Last <i>Bowers</i>					15. MOTHER'S MAIDEN NAME First <i>Mandella</i> Middle <i>Hansberg</i> Last <i>Hansberg</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <i>217-01-5434</i>		17. INFORMANT <i>Iva Rupp</i> Address <i>859 Broadhurst Baltimore Md.</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiovascular collapse</i> <i>428X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>multiple emboli</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>myocarditis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR AM Month Day Year <i>19</i>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>March 2</i> 19 <i>69</i> , to <i>March 15</i> 19 <i>69</i> , that (I) (we) lost the deceased alive on <i>March 15</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>W.R. Ehrmantrant MD</i> DEGREE <i>MD</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <i>3/17/69</i>						
22d. PHYSICIAN'S NAME (Type) <i>W. R. Ehrmantrant</i>										22e. ADDRESS <i>1125 Rockville Pike Rockville Md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					23b. DATE <i>3-18-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Pine Grove</i>			23d. LOCATION (City or Town) <i>Rockville</i> (County) <i>Montgomery</i> (State) <i>Md</i>						
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>					ADDRESS <i>Cathetersburg Md</i>					25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
DATE <i>MAR 20 1969</i>																

04037

REPUBLIC OF CHINA

100000

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Velt - BRAZIEL						Month Day Year			6
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	W	9-11-01	67 YRS.	MONTHS	DAYS	Month Day Year			6
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			MD
Ga.		U.S.				MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Spring		Holy Cross Hosp.			DR. P. K. K.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Md.			PRINCE GEORGES		HYATTSVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4001 WARNER AVE.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
R.G. Braziel			Whitley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
NO			NO			WIFE HYATTSVILLE, MD. ANNA P. BRAZIEL 4001 WARNER AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Coronary Insufficiency Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. P.M.		19				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22b. DATE SIGNED									
3/23/1969									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
BURIAL			3-27-69			CEDAR HILL CENT.			SUITLAND, MD.
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Lee FUNERAL HOME			DA			MAR 26 1969			
300-4 ST NE DR						J. Charles Jones			

22630

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04023		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04016			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR A.M.	
Alma Billie Brooke						March 24, 1969		12:45	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		March 4, 1910		59 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
North Carolina		America				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Washington Sanitarium		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Wheaton				11723 Highview Avenue	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
John Hicks						Gertrude Bolick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address			
no		579-12-4017		Patient's chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver cancer</u> 5710 DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>3/5</u> , 19 <u>69</u> , to <u>3/25</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3/25</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				
<u>Lewis H. Dennis, MD</u>		3/24/69			<u>Lewis H. Dennis, MD</u>				
22e. ADDRESS		22f. REGISTRAR'S SIGNATURE							
8306 Bulbre Rd. Silver Spring, Md.		<u>Johnas J. Jones</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/27/69		Fort Lincoln Cemetery		Washington, D. C.			
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE			
<u>Warner E. Pumphrey, Inc.</u>		8434 Georgia Avenue		MAR 28 1969		<u>Johnas J. Jones</u>			
VR A15 45M - 1									

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CRITICAL OF WASH

0403

10-1-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04024		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04017			
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR	
First		Middle		Last		Month		Day	
Wilbur		Reynolds		Brooks		March		14	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Caucasian		6 September 1911		57 YRS.		MONTHS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		IF UNDER 24 HRS.	
Illinois		USA				Montgomery		HOURS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Naval Hospital, Bethesda		U.S. Navy					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Delaware		Kent		Milford		P.O. Box 411 RR#2			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT	
First		Middle		Last		First		Middle	
Wilbur		Brooks		unknown				Address	
								Milford	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		Milford	
Yes		1930-1960		331 07 3893		Margaret Brooks		P.O. Box 411 RR#2 Delaware	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3959 IMMEDIATE CAUSE (a) Aortic Stenosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 12 March, 19 69, to 14 March 19 69, that (X) (we) last saw the deceased alive on 12 March 19 69, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death:									
22b. SIGNATURE ✓ J. H. Hornbaker Jr MD		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 17 Mar 69			
22d. PHYSICIAN'S NAME (Type)		J. H. HORNBAKER, JR., M. D.		22e. ADDRESS Naval Hospital, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/19/69		Odd Fellows Cemetery		Milford, Del.			
24. FUNERAL DIRECTOR		Berry Funeral Home		Northwest Front St. Delaware		25a. REC'D BY REGISTRAR MAR 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

250 NO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)
304 REV. 1-58

04025		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04018			
Bennie Brotman						CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR	
BENNIE BROTMAN				BROTMAN		March 19 1969		10:45 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		12-15-05		63 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Russia		U.S.				MONTGOMERY CO		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		HOMECROSS HOSP.		Retired		BUTCHER			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.		MONTGOMERY		SILVER SPRING				8107 EASTERN AVE	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last							
BENJAMIN BROTMAN		KATE FLEISHER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
				JERRY BROTMAN 7723 GROTON RD BALTIMORE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular fibrillation + cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes mellitus myocardial infarction</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 2 years			
2509									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>cholesterol for intestinal obstruction due to regional enteritis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
3-17-69		Intestinal obstruction							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 1954, to 3-19, 1969, that (I) (we) last saw the deceased alive on 3-19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jason Geider M.D.		22c. DATE SIGNED 3-19-69		22d. PHYSICIAN'S NAME (Type) JASON GEIDER, M.D.		22e. ADDRESS 500 PERSHING DRIVE SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/21/69		23c. NAME OF CEMETERY OR CREMATORY Beth Shalom Cn.		23d. LOCATION (City or Town) (County) (State) Hillside Md			
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS - WASHINGTON DC		25a. REC'D BY REGISTRAR MAR 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

84852

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04026		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04019					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR			
Willard Harrison Brown						March 28, 1969		3P. M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		Aug. 29, 1888		80 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Montgomery Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Monrovia		RFD # 1		Farmer							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Montgomery		Monrovia				RFD # 1			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John			--		Brown	Frances			--		Burdette
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No			213-42-7422		Winfred W. Brown, R#1, Monrovia, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>3/26</u> , 19 <u>68</u> , to <u>3/28</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>James P. Kerr</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED March 29, 1969						
22d. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.					22e. ADDRESS Damascus, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		March 31, 1969		Mt. View			Pardum, Maryland				
24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.					25a. REC'D BY REGISTRAR DATE APR 3 1969		25b. REGISTRAR'S SIGNATURE <u>W. Charles Judge</u>				

10052

EXTRACT OF THE

NAME	RESIDENCE	OCCUPATION	EDUCATION	REMARKS
J. A. Smith	123 Main St, New York	Teacher	High School	Good
M. B. Jones	456 Oak Ave, Chicago	Engineer	College	Excellent
C. D. Brown	789 Elm St, Boston	Lawyer	University	Very Good
E. F. White	321 Pine St, Philadelphia	Doctor	Medical School	Good
H. G. Black	654 Maple St, San Francisco	Merchant	High School	Fair
K. L. Green	987 Cedar St, Los Angeles	Farmer	College	Good
N. P. Hall	210 Birch St, Portland	Clerk	High School	Fair
S. Q. Young	543 Spruce St, Seattle	Artist	Art School	Excellent
T. R. King	876 Willow St, Denver	Writer	College	Good
V. S. Lee	109 Ash St, San Diego	Engineer	University	Very Good
W. T. Scott	432 Hickory St, Dallas	Teacher	High School	Fair
X. U. Adams	765 Walnut St, New Orleans	Lawyer	Law School	Excellent
Y. V. Baker	098 Elm St, St. Louis	Merchant	College	Good
Z. W. Carter	321 Pine St, Memphis	Farmer	High School	Fair
A. X. Evans	654 Maple St, Little Rock	Engineer	University	Very Good
B. Y. Fisher	987 Cedar St, Jackson	Clerk	High School	Fair
C. Z. Gibson	210 Birch St, Birmingham	Artist	Art School	Excellent
D. A. Hardy	543 Spruce St, Mobile	Writer	College	Good
E. B. Ingram	876 Willow St, Montgomery	Teacher	High School	Fair
F. C. Jordan	109 Ash St, Selma	Engineer	University	Very Good
G. D. Keith	432 Hickory St, Phenix City	Merchant	College	Good
H. E. Lester	765 Walnut St, Columbus	Farmer	High School	Fair
I. F. Mason	098 Elm St, Tallahassee	Engineer	University	Very Good
J. G. Nichols	321 Pine St, Panama City	Clerk	High School	Fair
K. H. Olsen	654 Maple St, Marietta	Artist	Art School	Excellent
L. I. Parker	987 Cedar St, Albany	Writer	College	Good
M. J. Quinn	210 Birch St, Schenectady	Teacher	High School	Fair
N. K. Roberts	543 Spruce St, Binghamton	Engineer	University	Very Good
O. L. Scott	876 Willow St, Elmira	Merchant	College	Good
P. M. Taylor	109 Ash St, Oneonta	Farmer	High School	Fair

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04027									
CERTIFICATE OF DEATH									
04020									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Franklin			Richard Bruns			March 19 1969			12:30
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		September 13, 1883			85 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		America				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park			Washington Sanitarium & Hops			Protective Agency			
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Montgomery		Takoma Park		YES		517 Albany Avenue
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Brinn William Bruns			Hadwig Hanfield						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			120-12-6875		Patinet's chart				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE</u> <u>months</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROSIS</u> <u>YEARS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>DIABETES</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>3-17</u> , 19 <u>64</u> , to <u>3-17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-17</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John L Ford M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3-19-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>JOHN L. FORD M.D.</u>					22e. ADDRESS <u>831 UNIVERSITY BLVD E SILVER SPRING, MD 20903</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
<u>Burial</u>		<u>March 21-1969</u>		<u>Madison Cemetery</u>		<u>Brownsville</u>		<u>N.Y.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>					ADDRESS <u>Washington, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
REC'D BY REGISTRAR <u>Arthur Walters</u>					DATE <u>March 20 1969</u>				

04028

04028

04028

1



3
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04028

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04021

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Estella			Charlotte	Bucknam	Month March			Day 22	Year 1969	3:25AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS	
Female		White		June 13, 1874		94 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Wisconsin		America				Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington San & Hospital								
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Montgomery		Rockville				17910 Cashell Road		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Henry			Taylor	Margaret	Everhart						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
no			392-52-5510		Patient's Chart						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 5901 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PYELONEPHRITIS DUE TO, OR AS A CONSEQUENCE OF (c) INTRACTABLE INFECTION WEEKS MONTHS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CONGESTIVE HEART FAILURE, CHRONIC											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from 2-6, 1967, to 3-22, 1967, that (1) (we) last saw the deceased alive on 3-21, 1967, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John L Ford MD						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/22/69			
22d. PHYSICIAN'S NAME (Type) JOHN LOUIS FORD						22e. ADDRESS 831 UNIVERSITY BLVD. SILVER SPRING MD. 20903					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial			March 24, 1969		Monocacy Cemetery		Beallsville,				Md.
24. FUNERAL DIRECTOR J. Arthur Walters, 254 Carroll St N.W. Wash. DC						25a. REC'D BY REGISTRAR DATE MAR 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

25030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04029

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04022

1. DECEASED-NAME (Type or print) Daisy May			First Middle Last			2a. DATE OF DEATH Month 3 Day 13 Year 69			2b. HOUR 6:25 PM					
3. SEX Female			4. RACE White			5. DATE OF BIRTH 6-29-82			6. AGE (In years last birthday) 86 YRS.					
7a. BIRTHPLACE (State or foreign country) Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY none					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Montg.			13c. CITY OR TOWN Silver Spg.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 10617 Tenbrook Dr.		
14. FATHER'S NAME James			First Middle Last			15. MOTHER'S MAIDEN NAME Louisa			First Middle Last Thompson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO. 578-16-5047 B			17. INFORMANT Records of Montgomery General Hosp.			Address Olney, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4379 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Heart Disease														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 69 , to 3/13 69 , that (I) (we) last saw the deceased alive on 3/13 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Allan B. Cohan, M.D.						22c. DATE SIGNED 5/13/69			22d. PHYSICIAN'S NAME (Type) Allan B. Cohan, M.D.					
22e. ADDRESS 13515 Georgia Ave. Silver Spring, Md. 20906														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 17, 1969			23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.					
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.						24a. REC'D BY REGISTRAR DATE M.F. 19 1969			25b. REGISTRAR'S SIGNATURE Charles Judge					

03089

1

77-10-107

19 288

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Register and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04030

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04023

1. DECEASED-NAME (Type or print) First Middle Last Annie Harrison Burwell			2a. DATE OF DEATH 3 Month 12 Day 69 Year		2b. HOUR M
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH 9/30/1887		6. AGE (In years last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Statesville, N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) School teacher		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.	13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2822 Sherman Ave., N. W.	
14. FATHER'S NAME First Middle Last Robert Murdock		15. MOTHER'S MAIDEN NAME First Middle Last Rebecca Austin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 579-60-9045	17. INFORMANT Address Dr. Hartford Burwell see 13E Wash., D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardio vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1 Sept 1968 to 12 March 1969 , that (I) (we) lost saw the deceased alive on 11 March 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Walter E. Goozh				22c. DATE SIGNED March 12 1969	
22d. PHYSICIAN'S NAME (Type) Walter E. Goozh, M.D.				22e. ADDRESS 2309 Shorefield Road Silver Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/15/69	23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION (City or Town) (County) (State) Highland Park, Maryland	
24. FUNERAL DIRECTOR Robert E. Goozh		1820 9th St., N.W. Washington, D.C.		25a. REC'D BY REGISTRAR MAR 17 1969	
				25b. REGISTRAR'S SIGNATURE Robert E. Goozh	

04030

CRIMINAL RECORD

2309 Thorsland Road
Silver Spring, Maryland

Major, George, B.

1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04031

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04024

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P		
Baby Boy			Butler			March 8, 1969			1:05 M		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH March 8, 1969		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5300 46th Ave.,		
14. FATHER'S NAME Irvin			First Middle Last - Payne		15. MOTHER'S MAIDEN NAME Valeria Cecelia Butler			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mother						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IMMATUREITY</u> 7692 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PREMATURE DELIVERY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYDRAMNIOS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>N. Stoehr</u>						DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-8-69	
22d. PHYSICIAN'S NAME (Type) N. Stoehr, M.D.,						22e. ADDRESS 831 University Blvd., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE 3-9-69		23c. NAME OF CEMETERY OR CREMATORY Washington San & Hospital			23d. LOCATION (City or Town) (County) (State) Takoma Park, Mont., Md.			
24. FUNERAL DIRECTOR J.D. Ruffcord, Takoma Park, Maryland						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE MAR 11 1969 <u>Charles Judge</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 4 Film 410

3/27/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04025

1. DECEASED-NAME (Type or Print) Maria			First Casilda			Middle Cabrejas			Last			2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month March Day 19 Year 1969			2b. HOUR 11A M														
3. SEX Female			4. RACE White			5. DATE OF BIRTH 4-9-88			6. AGE (In years last birthday) 80 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS 0			IF UNDER 24 HRS. HOURS 0 MIN. 0			2c. DATE PRONOUNCED DEAD Month March Day 19 Year 1969			2d. HOUR 11A M								
7a. BIRTHPLACE (State or foreign country) Cuba						7b. CITIZEN OF WHAT COUNTRY? U.S.A.						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. COUNTY OF DEATH Montgomery Md.											
10. CITY OR TOWN OF DEATH Bethesda						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife						12b. KIND OF BUSINESS OR INDUSTRY Own home											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.						13b. COUNTY Montgomery						13c. CITY OR TOWN Wheaton						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET AND NUMBER 11919 Lafayette Drive					
14. FATHER'S NAME Rafa el Manuela						First Manuela						Middle Corrales						Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO. 220-60-4706						17. INFORMANT Son - Joaquin Cabrejas						ADDRESS Same											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage - 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cardio Vascular Disease & Diabetes Mellitus - DUE TO, OR AS A CONSEQUENCE OF (c) Arterio Sclerosis - generalized - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days. years.																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture of Lumbar Spine -																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1-19 1969 P.M. PM						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell out of bed.																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home						21f. LOCATION Street or R.F.D. No. 11919 Lafayette Drive City or Town Wheaton County Montgomery State Md.																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE John G. Ball						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22b. DATE SIGNED 19 March 1969.																	
EXAMINER'S NAME (Type) John G. Ball, M.D.						ADDRESS (Street, city, town, or county) 48434 Georgia Avenue																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE March 22, 1969						23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery Silver Spring, Montgomery, Md.																	
24. FUNERAL DIRECTOR Warner E. Pumpkney, Inc.						25a. REC'D BY REGISTRAR MAR 24 1969						25b. REGISTRAR'S SIGNATURE Charles Judge																	

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
04033												
CERTIFICATE OF DEATH												
04026												
1. DECEASED-NAME (Type or print) EDWIN			First H.		Middle CAGE		Lost		2a. DATE OF DEATH Month MARCH Day 4 Year 1969		2b. HOUR 3⁴⁵ A M	
3. SEX M		4. RACE WHITE		5. DATE OF BIRTH 11-5-10			6. AGE (In years lost birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS 11 DAYS 11		IF UNDER 24 HRS. HOURS 11 MIN.	
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONT GOMERY Md.						
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Civilian Employee Air Force			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Silver Spring 218 St. Lawrence Drive Md.				
14. FATHER'S NAME First Benjamin Middle H. Last Cage			15. MOTHER'S MAIDEN NAME First Alma Middle Wilson Last Wilson									
16a. WAS DECEASED EVER Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-16-3192		17. INFORMANT Address Silver Spring, Md. Mrs. Rebecca K. Cage 218 St. Lawrence Drive								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, unknown primary site 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH approx.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Oct 1965 to 3/4 1969 , that (I) (we) last saw the deceased alive on 3/3 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE G. Leonard Gold				DEGREE MD.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/4/69				
22d. PHYSICIAN'S NAME (Type) G. Leonard Gold				22e. ADDRESS 9801 Ga. Avenue Silver Spring, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 7, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland						
24a. FUNERAL DIRECTOR G. Glen Carter				ADDRESS 8434 Georgia Avenue		25a. REC'D BY REGISTRAR DATE MAR 10 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge				
Warner E. Pumphrey, Inc. Silver Spring, Md.												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

VR A15
45M - 1969

04034		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04027	
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
First		Middle		Last		Month	Day
PETER		C		CAMERON		MARCH	6
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
MALE		WHITE		8-6-1896		12	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
PENNA.		USA				Montgomery	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban		RECORD - SALES		ELECTRONICS	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Md.		Montgomery		Bethesda		4625 Rivier Rd	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	
First		Middle		Last		Address	
WILLIAM W. CAMERON		LILLY		CARVEY			
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. MEDICAL CERTIFICATION		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MRS. BETTY F. CAMERON, WIDOW, SAMEX #13		PART 1. DEATH WAS CAUSED BY:					
		IMMEDIATE CAUSE (a)		Respiratory Insufficiency		2 days	
		DUE TO, OR AS A CONSEQUENCE OF		(b) Pulmonary Edema and Pleural Effusion		10 days	
		DUE TO, OR AS A CONSEQUENCE OF		(c) Acute anterior myocardial infarction			
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)		Primary arteriosclerosis severe			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 1966, to 3/6, 1969, that (I) (we) last saw the deceased alive on 3/5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE J. Blaine Fitzgerald M.D.		22c. DATE SIGNED 3/6/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		23a. BURNAL CREMATION, REMOVAL (Specify)		23b. DATE	
		Bethesda Maryland		Burial		3-8-1969	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
Parklawn Cemetery		Rockville, Montgomery Co., Md.		Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		DATE MAR 10 1969	
						25b. REGISTRAR'S SIGNATURE Charles Judge	

[Faint, illegible handwriting in the top section of the form, likely containing personal information.]

[Faint, illegible handwriting in the middle section of the form, likely containing medical or cause-of-death information.]

[Faint, illegible handwriting in the bottom section of the form, likely containing signature and date information.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P			
Joseph Rodman Carpenter						March 24 1969		9:20 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Male		White		3/21/90		79					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Michigan		U.S.A.				Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney			Montgomery General Hospital			Accountant					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Montgomery		Sandy Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		1701 Norwood Road		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
William T. Carpenter						Ella M. Jackson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT						
no			281-09-7070		records Address Montgomery General Hospital, Olney, Md. 20832						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Stomach Pneumonia Rt side</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes Mellitus</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/9/68</u> to <u>3/25/69</u> , that (I) (we) saw the deceased alive on <u>3/24/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)					
<u>Charles H. Ligon, M.D.</u>			3/25/69			Sandy Spring, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation			March 26 1969		Lee Funeral Home		Washington D.C.				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR								
Francis H. Barber Laytonsville Md.			25b. REGISTRAR'S SIGNATURE <u>Charles Ligon</u>								

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 14 & 15 Film GL 11
4/2/69 kdk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04036

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04029

1. DECEASED-NAME (Type or Print) James Melvin CARTER			2a. DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Mar 12 1969			2b. HOUR 715 M			
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH Oct 20, 1931	6. AGE (in years last birthday) 37 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Mar 12 1969			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U. S. Marine Corps		12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 2730 Hugo Avenue			14. FATHER'S NAME First Walter Middle James Last Carter			15. MOTHER'S MAIDEN NAME First Nicolas Middle Lovelean Last Walton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. 1951-1969		17. INFORMANT Marine Corps records			ADDRESS WASH, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe peritonitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Gunshot wounds of abdomen DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 53 days 53 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 330 Jan 18 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot by another man				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No. City or Town County State 203 North Eaden St. Baltimore Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John G. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 13 March 1969			
EXAMINER'S NAME (Type) John G. BALL, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county)			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3-17-69			
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore Md.			23d. LOCATION (City or Town) (County) (State) Baltimore Md.						
24. FUNERAL DIRECTOR W. W. Chambers Co.			ADDRESS 1400 Chapin Street, N. W. Washington, D.C.			25a. REC'D BY REGISTRAR MAR 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04037												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												04030											
1. DECEASED-NAME (Type or print) First Middle Last Christopher Dane Cassimus												2a. DATE OF DEATH Month Day Year 3 25 69												2b. HOUR 11:55P											
3. SEX Male				4. RACE White				5. DATE OF BIRTH 12-24-90				6. AGE (In years last birthday) 78 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.															
7a. BIRTHPLACE (State or foreign country) Canada				7b. CITIZEN OF WHAT COUNTRY? Amer. USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md.																							
10. CITY OR TOWN OF DEATH Takoma Park				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Restaurant owner				12b. KIND OF BUSINESS OR INDUSTRY Restaurant																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Wheaton				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 11505 Higby St																			
14. FATHER'S NAME First Middle Last Danny Cassimus						15. MOTHER'S MAIDEN NAME First Middle Last XXXXXX Pearl ?																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown unknown				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 228-05-0322				17. INFORMANT Mary L. Cassimus Address wife XXXXXX XXXXXX 11505-Higby St. S.S. Md Hospital record																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION - ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES 6 YEARS																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) DIABETES MELLITUS. EMPHYSEMA																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from July, 1952, to March 23, 1969, that (I) (we) lost the deceased on March 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE Robert L. Krichmarc DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED March 26 1969																																			
22d. PHYSICIAN'S NAME (Type) ROBERT L. KRICHMARMD 22e. ADDRESS 7733 ALASKA AVENUE N.W. WASHINGTON DC 20012																																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE March 28, 1969				23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery, Md.																							
24. FUNERAL DIRECTOR C. Glen Carter 434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.												25a. REC'D BY REGISTRAR DATE APR 1 1969				25b. REGISTRAR'S SIGNATURE																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04038		CERTIFICATE OF DEATH						04031	
1. DECEASED-NAME (Type or print) CHARLES WESTON CASWELL				2a. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1969</u>				2b. HOUR <u>11:30 P.M.</u>	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 9/19/91		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> HOURS <u> </u> MIN <u> </u>	
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Beth.-Sil. Spr. N.H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Asst. Director ICC		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY ----		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4201 Mass. Ave., N.W.	
14. FATHER'S NAME First Edward Middle R. Last Caswell		15. MOTHER'S MAIDEN NAME First Minnie Middle -- Last Weston							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give year or dates of service) ----		16b. SOCIAL SECURITY NO. 578-50-8270A		17. INFORMANT Address John F. Caswell, Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4124</u> (b) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio-Sclerotic Cardio-Vascular Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 weeks</u> <u>3 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u> </u> <u> </u> <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>March 17</u> , 19 <u>69</u> , to <u>March 17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 17</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Samuel Diener, M.D.</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/17/69</u>			
22d. PHYSICIAN'S NAME (Type) Samuel Diener				22e. ADDRESS 4201 Mass. Ave, NW, Wash., D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial/Transit		23b. DATE 3/22/69		23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		23d. LOCATION (City or Town) (County) (State) Troy, New York			
24. FUNERAL DIRECTOR Jos. Gawler's Sons, 5130 Wis. Ave, NW, Wash., D.C.				25a. REC'D BY REGISTRAR MAR 20 1969		25b. REGISTRAR'S SIGNATURE <u>W. Charles G. Gaudet</u>			

00038

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

100-100000-100

[Illegible text continues]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
30M REV. 1/68

04039		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04032											
Item 6 Film 0410 3/14/69 kk																	
1. DECEASED-NAME (Type or print)				First Rus y		Middle B.		Last CAVE		2a. DATE OF DEATH Month March		Day 6		Year 69		2b. HOUR 4:30 P	
3. SEX F		4. RACE Cav		5. DATE OF BIRTH Jan 30, 1885				6. AGE (In years last birthday) 83 82		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		HOURS		MIN.	
7a. BIRTHPLACE (State or foreign country) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Mont.						Md					
10. CITY OR TOWN OF DEATH Bensington, Md.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bensington Gardens N. H.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Mont.		13c. CITY OR TOWN Glen Echo		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 25 Wellesley Circle							
14. FATHER'S NAME George Frederick				First Fifer		Middle Last		15. MOTHER'S MAIDEN NAME MARY Elizabeth				First Burnett		Middle Last			
16a. WAS DECEASED EVER Yes, no, or unknown)				IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. none		17. INFORMANT Robert T. Fifer				Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: 4379 IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral vessels</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>aneurism</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>dissection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natlly medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from June, 1965, to March 6, 1969, that (I) (we) last saw the deceased alive on March 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE [Signature]				MD DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 3/6/69					
22d. PHYSICIAN'S NAME (Type)				G.F. Kreuzburg				22e. ADDRESS 7852 16th St NW Wash DC									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE Mar. 7, 1969				23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory				23d. LOCATION (City or Town) (County) (State) Wash. D.C.					
24. FUNERAL DIRECTOR Lee Fun. Home, 300 4th St. N.E., D.C.				ADDRESS				25a. REC'D BY REGISTRAR DATE MAR 10 1969				25b. REGISTRAR'S SIGNATURE Charles Judge					

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STATE OF NEW YORK

IN SENATE

January 1, 1900

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1899

ALBANY:

JOHN B. LANE, PRINTERS

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CLEARED WITH MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04040

CERTIFICATE OF DEATH

04033

1. DECEASED-NAME (Type or print) First <u>Marlene</u> Middle <u>Sandra</u> Last <u>CHARROW</u>			2a. DATE OF DEATH Month <u>MARCH</u> Day <u>29</u> Year <u>1969</u>			2b. HOUR <u>10¹⁵ A.M.</u>					
3. SEX <u>FEMALE</u>		4. RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH <u>12-20-35</u>		6. AGE (In years last birthday) <u>33</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN <u></u>	
7a. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY</u> Md.					
10. CITY OR TOWN OF DEATH <u>TAKOMA PARK</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WASHINGTON SANITARY HOSPITAL</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>ADMINISTRATOR</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>CIBA</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before, admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>WHEATON</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>3404 HEWITT AVE</u>			
14. FATHER'S NAME First <u>CHARLES</u> Middle <u>X</u> Last <u>X</u>		15. MOTHER'S MAIDEN NAME First <u>JACQUELINE</u> Middle <u>AUGUSTE</u> Last <u>X</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>579-44-7705</u>		17. INFORMANT <u>Roderick Charron-3404 Hewitt Ave., S.S., Md.</u>		Address <u>#207</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>4309</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>3/29</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>G. Lennard Gold</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/29/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold</u>				22e. ADDRESS <u>9801 Georgia Ave., Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 2, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Pr. Geo. Maryland</u>					
23e. FUNERAL DIRECTOR <u>C. Glen Carter</u>		23f. ADDRESS <u>8434 Georgia Avenue</u>		23g. BY REGISTRAR <u>APR 3 1969</u>		23h. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					
23i. FUNERAL HOME <u>Warner E. Pumphrey, Inc.</u>		23j. ADDRESS <u>Silver Spring, Md.</u>									

04000

STATE OF TEXAS

04000

IN SENATE, FEBRUARY 1, 1901.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE.

FOR THE YEAR ENDING DECEMBER 31, 1900.

ALBUQUERQUE, N. M., FEBRUARY 1, 1901.

PRINTED BY THE STATE OF TEXAS.

RECEIVED FEBRUARY 1, 1901.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04034		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) First JOEWAYNE Middle JOSEPH Lost CLARK						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 15 Year 19 69			2b. HOUR 10:45 P.M.			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 5-18-39		6. AGE (in years lost birthday) 29 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) D. C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			Md.	
10. CITY OR TOWN OF DEATH Olney				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Simpsonville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 305 Freetown Road		
14. FATHER'S NAME First Unknown Middle Lost						15. MOTHER'S MAIDEN NAME First Elsie Clark Middle Lost						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. 217-34-0119		17. INFORMANT Elsie Clark: same as above: ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 965X IMMEDIATE CAUSE (a) Bullet wound of abdominal aorta with exsanguination DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) exsanguination DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 9:40 A.M. 3-15 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased shot during a dispute with another man.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) Beer tavern		21f. LOCATION Street or R.F.D. No. Silver Spring City or Town Montg. County Md. State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Belden R. Keap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 3/16/1969				
EXAMINER'S NAME (Type) BELDEN R. KEAP				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE 3-20-69		23c. NAME OF CEMETERY OR CREMATORY Church Cemetery,				23d. LOCATION (City or Town) (County) (State) Sandy Spring, Md.				
24. FUNERAL DIRECTOR Robert L. Snowden ADDRESS Rockville, Md.						25a. REC'D BY REGISTRAR MAR 21 1969 DATE		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04042		CERTIFICATE OF DEATH						04035	
1. DECEASED-NAME (Type or print) <i>Evelyn H Clarke</i>					2a. DATE OF DEATH Month <i>March</i> Day <i>7</i> Year <i>1969</i>			2b. HOUR <i>9:30</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>1924/2/1</i>		6. AGE (In years last birthday) <i>45</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Mich</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Shubank Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>R.N.</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>582 College Pkwy.</i>	
14. FATHER'S NAME First <i>William</i> Middle <i>Zimke</i> Last <i>Zimke</i>			15. MOTHER'S MAIDEN NAME First <i>Gloria</i> Middle <i>Armenington</i> Last <i>Armenington</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>225-34-0872</i>		17. INFORMANT <i>Husband</i>		Address <i>Same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4319 Intracranial hemorrhage, massive, left hemisphere</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from <i>1956</i> to <i>March 6, 1969</i> , that (1) (we) last saw the deceased alive on <i>March 5, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>G. Bowditch Hunter</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>March 7, 1969</i>				
22d. PHYSICIAN'S NAME (Type) <i>G. Bowditch Hunter</i>					22e. ADDRESS <i>30 W. Edmondston Drive, Rockville, Md</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/11/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>			
24. FUNERAL DIRECTOR <i>Tyson Wheeler</i> <i>Funeral Home Rockville, Md.</i>					25a. REC'D BY REGISTRAR <i>MAR 12 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

04045

CERTIFICATE OF DEATH

STATE OF NEW YORK

1

2-2-1972

50 W. Edmondson Drive, Rockville, Maryland
171 Rock. Ave.
Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04043		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04036	
1. DECEASED-NAME (Type or print)			First	Middle	Last
James Earl Clementson					
3. SEX		4. RACE	5. DATE OF BIRTH		2a. DATE OF DEATH
Male		Cau.	12/1/99		Month 3 Day 26 Year 69
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		2b. HOUR
D.C.		U.S.A.	9. COUNTY OF DEATH Montgomery		3:20P ^M
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Bethesda, Md.		Gros. Lane Nursing Home		Clerk-Army Map Service	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	12b. KIND OF BUSINESS OR INDUSTRY
D.C. MD.		Montgomery	Washington	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Govt.
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME
James H. Clementson					Clara Poor
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		577-03-6439		Mrs. D.C. McNulty, 5909 Sonoma Rd., Beth., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebric</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of Colon's metastases to Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 1/2 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
Sept 1965		Cancer of Transverse Colon		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from August 10, 1965, to April 24, 1969, that (I) (we) last saw the deceased alive on March 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)	
<u>E. Stuart Lyddane</u>		3/24/69		E. Stuart Lyddane	
22e. ADDRESS		3066 Q St., N.W., Wash., D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)
Burial		3-29-69	CEDAR HILL CEMETERY		SWITLAND, MD.
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. DeLoe		APR 1 1969		<u>Charles Judge</u>	

100-443

DATE: 10/10/50 TIME: 10:10 AM

TO: SAC, NEW YORK (100-443) FROM: SAC, NEW YORK (100-443)

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

04044		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04037	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) JACOB DAVID COHEN			2a. DATE OF DEATH Month MAR Day 20 Year 1969			2b. HOUR 4:19 M	
3. SEX male		4. RACE WHITE		5. DATE OF BIRTH 6/18/96		6. AGE (In years last birthday) 72 YRS.	
7a. BIRTHPLACE (State or foreign country) Lithuania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11201 GAINSBOROUGH ROAD	
14. FATHER'S NAME First MAX Middle COHEN Last COHEN		15. MOTHER'S MAIDEN NAME First BESSIE Middle COHEN Last COHEN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 013-28-6052		17. INFORMANT DR. SIDNEY J. COHEN		Address 11201 GAINSBOROUGH ROAD POTOMAC, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema and Pleural Effusion DUE TO, OR AS A CONSEQUENCE OF (c) Marked Coronary Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 days 2 weeks 2 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/5/1969 , to 3/20/1969 , that (I) (we) last saw the deceased alive on 3/19/1969 , and that in (any) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert C. Macdon		DEGREE ROBERT C. MACON		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/20/69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 809 Viers Mill Rd. - Rockville, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Mar. 21, 1969		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden Falls Church, Virginia		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Donald M. Stein		ADDRESS 232 Carroll		25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE Robert C. Macdon	
Hebrew Memorial Funeral Home St., N.W. Wash., D.C.							

04042

STATE OF TEXAS

County of

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04045

CERTIFICATE OF DEATH

04038

1. DECEASED-NAME (Type or print) Max First Harry Middle Cohen Last		2a. DATE OF DEATH Month 3 Day 11 Year 69		2b. HOUR 1.45p M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 6.13.79	
7a. BIRTHPLACE (State or foreign country) Lithuania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tailor	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME First Jacob Middle Last Cohen		15. MOTHER'S MAIDEN NAME First Eva Middle Last ?		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no	
16b. SOCIAL SECURITY NO. 577-09-9925		17. INFORMANT Medical Record Dept.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1541 IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rectal Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1/30 , 19 67 , to 3/11 , 19 69 , that (I) (we) last saw the deceased alive on 3/11 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alan B. Cohen M.D.		22c. DATE SIGNED 3/11/69		22d. ADDRESS 13515 Georgia Ave., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-12-1969		23c. NAME OF CEMETERY OR CREMATORY Ohev Sholom Cemetery	
24. FUNERAL DIRECTOR Goldberg Funeral Home		23d. LOCATION (City or Town) (County) (State) Washington D. C.		25a. REC'D BY REGISTRAR MAR 14 1969	
25b. REGISTRAR'S SIGNATURE J. Charles Judge					

04045

OFFICE OF DEATH

0000

NAME: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible] MANNER OF DEATH: [illegible]

REPORTING PHYSICIAN: [illegible] SIGNATURE: [illegible]

REPORTING OFFICER: [illegible] SIGNATURE: [illegible]

REPORTING AGENCY: [illegible] SIGNATURE: [illegible]

REPORTING OFFICER: [illegible] SIGNATURE: [illegible]

REPORTING AGENCY: [illegible] SIGNATURE: [illegible]

REPORTING OFFICER: [illegible] SIGNATURE: [illegible]

REPORTING AGENCY: [illegible] SIGNATURE: [illegible]

REPORTING OFFICER: [illegible] SIGNATURE: [illegible]

REPORTING AGENCY: [illegible] SIGNATURE: [illegible]

REPORTING OFFICER: [illegible] SIGNATURE: [illegible]

REPORTING AGENCY: [illegible] SIGNATURE: [illegible]

REPORTING OFFICER: [illegible] SIGNATURE: [illegible]

REPORTING AGENCY: [illegible] SIGNATURE: [illegible]

REPORTING OFFICER: [illegible] SIGNATURE: [illegible]

REPORTING AGENCY: [illegible] SIGNATURE: [illegible]

REPORTING OFFICER: [illegible] SIGNATURE: [illegible]

REPORTING AGENCY: [illegible] SIGNATURE: [illegible]

REPORTING OFFICER: [illegible] SIGNATURE: [illegible]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04046

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04039

1. DECEASED-NAME (Type or Print) Pauline Lucille			First Middle Last Colt			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month 3 Day 4 Year 69			2b. HOUR 10:30		
3. SEX F		4. RACE W		5. DATE OF BIRTH 2-22-04		6. AGE (In years last birthday) 65 YRS. MONTHS 0 DAYS 13		IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a. BIRTHPLACE (State or foreign country) Burlington, Vermont		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			2c. DATE PRONOUNCED DEAD Month 3 Day 4 Year 1969		
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired-Clerk		12b. KIND OF BUSINESS OR INDUSTRY Govt. Printing Office		13a. STREET AND NUMBER 6610 Eastern Ave. Wash. DC		13b. CITY OR TOWN Wash. D.C.	
14. FATHER'S NAME First Joseph A. Middle St. Last German		15. MOTHER'S MAIDEN NAME First Celia Middle Arnold Last Arnold		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 577-60-1218		17. INFORMANT Mr. Frank J. Colt		17a. ADDRESS 2652 Cory Terrace Wheaton, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Artery Heart Disease (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED March 4, 1969			
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, Town, or County)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 7, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR C. Glen Carter						ADDRESS 34 Georgia Avenue Silver Spring, Md.		DATE MAR 10 1969			

00000

RECEIVED
FBI



ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 01-10-2001 BY 60322 UCBAW/STP

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report body.]

MAR 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
04047													
CERTIFICATE OF DEATH													
04040													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Nathan			A. Conn			Month Day Year 3 13 69			5:10 PM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS				
male		white		11-19-84			84 YRS.		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.			
Lithuania		American born				Montgomery							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Takoma Park			Washington Sanitarium & Hospital			Patent Attorney							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Washington D.C.			Washington			D.C.		YES		2238 Cathedral Avenue NW			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Isaac Conn			Libby										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
No			579-52-3994			Records - Washington Sanitarium & Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Pneumonia										3 weeks			
DUE TO, OR AS A CONSEQUENCE OF (b) 4369										2 weeks			
DUE TO, OR AS A CONSEQUENCE OF (c) 4369										1 day			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
MEDICAL CERTIFICATION													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from March 23, 1969, to March 13, 1969, that (I) (we) lost saw the deceased alive on March 13, 1969, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE						22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
Charles H. Voloshin, M.D.						8312 Univ. Blvd E. Silver Spring							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			3/14/69			Cem. of Adas Israel Cong.			Wash., D.C.				
24. FUNERAL DIRECTOR										25. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Bernard Danzansky & Sons										301 14th St. Wash., DC		Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.D. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>04048</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>04041</div>									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Joseph Thompson Connolly						<input checked="" type="checkbox"/> Month Day Year Mar 17 69		<input type="checkbox"/> M 12:30 P	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	Nov. 12, 1902	66 YRS.	MONTHS 4	DAYS 6	Month Day Year March 17 1969		12:50 P M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Canada		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			Bethesda-Silver Spr. Nursing Home			Ret. U.S. Treasury Dept.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Maryland			Montgomery		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Highland House, Bethesda, Md.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Charles Connolly			Tina Fleming						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			none		Silver Spring, Md. Charles J. Connolly, 632 Whittingham Drive				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Congestive Heart Failure -									Weeks -
4124 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Cardio-Vascular Disease -									Years -
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John G. Ball					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) John G. Ball					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					ADDRESS (Street, city, town, or county)				
					22b. DATE SIGNED March 17/1969				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		March 20, 1969		Parklawn Cemetery		Rockville, Montgomery, Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
P.J. Smith 18434 Georgia Avenue					DATE MAR 24 1969		Charles Judge		
Warner E. Pumphrey, Inc. Silver Spring, Md.									

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First MARY	Middle FLORIDA	Lost COPLIN	2a. DATE OF DEATH Month 3 Day 1 Year 69		2b. HOUR A 10:00M	
3. SEX FEMALE		4. RACE NEGROE		5. DATE OF BIRTH 1/22/89		6. AGE (In year last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN LAYTONSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RT. 1, Box 139	
14. FATHER'S NAME First ROBERT Middle Last WASHINGTON		15. MOTHER'S MAIDEN NAME First BERTHA Middle Last --							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4123</u> (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>YRS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> , 19 <u>69</u> , to <u>3/1</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3/1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles Judge</u>		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Rockville Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED <u>3/1/69</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAR. 4, 1969		23c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cem.		23d. LOCATION (City or Town) (County) (State) Laytonsville Monty Md.			
24. FUNERAL DIRECTOR Robert L. Snowden		24b. ADDRESS Rockville Md.		25a. REC'D BY REGISTRAR MAR 4 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04050		CERTIFICATE OF DEATH				04043			
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Elmer F Corridon						March 4 1969			6:24 A M
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
M	W	8-21-90			78				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Wash DC		USA				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Suburban.						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		505 DARTMOUTH AVE.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
James F Corridon			Wenifred Keeley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			577-10-7564		Hester - Mrs Margaret Sartain		Home as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema & Bronchopneumonia 551.3 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastric ulcer with perforation & Esophageal ulcer DUE TO, OR AS A CONSEQUENCE OF (c) Acute Hernia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1955 to 4 March 1969, that (I) (we) last saw the deceased alive on 3 March 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William D. Auld					DEGREE ATTENDING PHYS.		MED. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4 March '69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
WILLIAM D. AULD					SILVER SPRING, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3-7-69		Mt Olivet Cemetery		Washington Md.			
24. FUNERAL DIRECTOR Francis Collins 500 Union Blvd. W. Silver Sp. Md.					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
					MAR 10 1969		Charles Judge		

MEDICAL CERTIFICATION

02020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04051					04044				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last George W. Courtney					2a. DATE OF DEATH Month Day Year March 8 1969			2b. HOUR MIN 2:30 M	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH Jan 3 - 1882		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) New York, N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nurs Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE New York			13b. COUNTY YONKERS		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 25 Livingston Ave		
14. FATHER'S NAME First Middle Last Robert Courtney			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Laughlin Laughlin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No, no, or (unknown)			16b. SOCIAL SECURITY NO. 075-09-3289A		17. INFORMANT Son - Geo Courtney		Address 1006 Kenan Court Rockville		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 4123 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Uremia secondary to benign prostatic hypertrophy</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb 22, 1969, to March 8, 1969, that (I) (we) last saw the deceased alive on March 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bouditch Hunter, Jr.					22c. DATE SIGNED March 8, 1969		22d. PHYSICIAN'S NAME (Type) Bouditch Hunter, Jr.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		23b. DATE 3/11/69		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope		23d. LOCATION (City or Town) (County) (State) Yonkers, New York			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home - 1331 Rockville Pike					25. REC'D BY REGISTRAR MAR 12 1969		25b. REGISTRAR'S SIGNATURE William A. Vande...		

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04052

CERTIFICATE OF DEATH

04045

1. DECEASED NAME (Type or print) MICHAEL P COVICH			2a. DATE OF DEATH Month 3 Day 8 Year 69			2b. HOUR 5 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 3/15/65		6. AGE (In years last birthday) 3 YRS.	
7a. BIRTHPLACE (State or foreign country) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CHILD		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 37 GRANDIN							
14. FATHER'S NAME First Phillip Michael Middle Corich Last Covich			15. MOTHER'S MAIDEN NAME First Judith Middle Rosamilia Last Covich				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT Father Address Same as item # 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 742 X Acute, purulent meningitis DUE TO, OR AS A CONSEQUENCE OF (b) Hydrocephalus DUE TO, OR AS A CONSEQUENCE OF (c) 3 years							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 3-4-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hydrocephalus		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5- , 19 65 , to 3-8 , 19 69 , that (I) (we) lost saw the deceased alive on 3-7- 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-5-69	
22d. PHYSICIAN'S NAME (Type) ALLAN B. COLEMAN, M.D.		22e. ADDRESS 1605 N. PORTER DR. NW. WASH. DC 20012					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/10/1969		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1331 Rockville Pike		25a. REC'D BY REGISTRAR 1331 Rockville Pike		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04023

RECORD R-12 2541

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RECORD R-12 2541

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3

X

04053 Cox James										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04046			
1. DECEASED-NAME (Type or print) First Middle Last James M Cox										2a. DATE OF DEATH Month Day Year March 16 1969										2b. HOUR 10:30 PM			
3. SEX M			4. RACE W			5. DATE OF BIRTH May 3 1897			6. AGE (In years last birthday) 71 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN								
7a. BIRTHPLACE (State or foreign country) Miss			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.														
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grosvenor Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Fireman			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE DC			13b. COUNTY Montgomery			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 5814 Sherrier Pl											
14. FATHER'S NAME First Middle Last John Cox			15. MOTHER'S MAIDEN NAME First Middle Last Ann Davis																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year and dates of service) Yes W			16b. SOCIAL SECURITY NO.			17. INFORMANT Address Aileen K Cox																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary atherosclerosis</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 4 months chronic									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 1969						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <u>3/16</u> , 19 <u>69</u> , to <u>3/16</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/16</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE David A Morowikz, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 3/16/69																							
22d. PHYSICIAN'S NAME (Type) David A Morowikz MD 22e. ADDRESS 3721 Grosvenor Lane Rockville, Md																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3-19-69			23c. NAME OF CEMETERY OR CREMATORY Culpepper National			23d. LOCATION (City or Town) (County) (State) Culpepper Virginia														
24. FUNERAL DIRECTOR Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md 25a. REC'D BY REGISTRAR MAR 24 1969 25b. REGISTRAR'S SIGNATURE Charles Judge																							

02-1-40

OFFICE OF THE ATTORNEY GENERAL

STATE OF CALIFORNIA

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04053

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items #4&13c, Film Gull, 4/7/69											
CERTIFICATE OF DEATH										04047	
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Mabel M. Creel						Month Day Year			48 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Caucasian		5-23-88		80 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Penna		U.S.A.				Montgomery			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Chevy Chase			Bethesda - Silver Spring Neuroscience								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md			Montgomery					2804 Cheeverly Ave			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
John E Writer			Caroline Fogle								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
no			220-48-7992			Edna Cole			Cheverly, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) ASHD to acute MI										2 wks	
DUE TO, OR AS A CONSEQUENCE OF											
(b) Corb arteriosclerosis										2 yrs	
DUE TO, OR AS A CONSEQUENCE OF											
(c) Acute Bacterial endocarditis & anemia										9 mo -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Anemia ? etiology											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M.									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work											
22a. I certify that (I) (this hospital) attended the deceased from 4-20, 1968, to 3-26, 1969, that (I) (we) last saw the deceased alive on 3/17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
Robert L. Flynn MD		3/26/69									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
ROBERT L. FLYNN MD		916 19th St NW Wash DC									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Mar 28, 1969		Glenwood Cemetery		Washington D. C.					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons				Hyattsville, Md.		MAR 28 1969		Charles Judge			

04024

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
45M - 1-1-69

04055		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04048		
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
James T Cross					March 10 1969			
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male	WHITE		1-20-96		73 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Wash. D.C.	U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville		Potomac Valley Nursing Home						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Md.		Montgomery		Gaithersburg		3 Highland Ave		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Cowan					Hilda F. Cross			Mary Thornton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
Yes, no, or unknown		577-09-2612		Hilda F. Cross				3 Highland Ave Gaithersburg Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC BRONCHOGENIC CARCINOMA 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from MAR. 6, 1969, to MARCH 10, 1969, that (I) (we) last saw the deceased alive on MAR 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Robert C. Daddario DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) ROBERT C. DADDARIO				22e. ADDRESS 5413 CEDAR LANE BETHESDA MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		3-12-69		Parklawn		Rockville md		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
GARTNER		MAR 13 1969		Charles Judge				

04055

RESEARCH DEPT

0201 11 11 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
04056													
04049													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR	
Albert				George Dabbs				Month Day Year				March 5 1969 3:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		2-24-1899				72 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9. COUNTY OF DEATH					
England		USA		WIDOWED		DIVORCED		Montgomery				Md	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda				Suburban				Butcher - Sausage Stores				SAFENAY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
md				Montgomery		Kensington		YES NO		3515 ANDERSON RD.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Albert Edward Dabbs				Hannah				TOMPKINS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT							
No				213-05-2730-A		Mrs. Elsie C. Dabbs		3515 Anderson Road Kensington Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Acute Congestive Heart Failure												4 wks.	
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) Auricular Fibrillation													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Arteriosclerotic Heart Disease													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
								YES NO					
21a. ACCIDENT WAS UNDERLYING				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)				HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
While Not while at work at work													
22a. I certify that (I) (this hospital) attended the deceased from Jan 25, 1969, to March 5, 1969, that (I) saw the deceased alive on March 4, 1969, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				22c. DATE SIGNED									
Robert T. Thibadeau				March 5 1969									
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS									
Robert T. Thibadeau				11,000 Old Georgetown Road Rockville, Maryland 20852									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial				March 8, 1969		St. Lincoln Cemetery		Bladensburg, Maryland					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
C. Glen Carter				8434 Georgia Avenue Silver Spring, Md.				MAR 12 1969 Charles Judge					

MEDICAL CERTIFICATION

02026

RECEIVED IN THE

DEPARTMENT OF THE ARMY

1950

Handwritten notes and signatures, including "John L. Tamm" and "John L. Tamm" in the top right corner.

Handwritten notes and signatures, including "John L. Tamm" and "John L. Tamm" in the middle right corner.

Handwritten notes and signatures, including "John L. Tamm" and "John L. Tamm" in the bottom right corner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (11-68)
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04057									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Aileen Gertrude Dalkin						March 17 1969		12:55A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR	
Female		Caucasian		Nov. 30, 1887		81 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Virginia		USA				Montgomery County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		9110 Providence Avenue		Homemaker		own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Silver Spring				9110 Providence Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William Robert Sanders			Anna Rogers						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			213-50-0997		Doris D. Stamp, College Park, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4339 Cerebral thrombosis						3 yrs.			
Generalized atherosclerosis						20 yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from Jan. 24, 1968, to March 17, 1969, that (I) (we) saw the deceased alive on March 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William B. Gunther, M.D.					22c. DATE SIGNED March 17, 1969		22d. PHYSICIAN'S NAME (Type)		
22e. ADDRESS 4917 Edgewood Road, College Park, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		March 19, 1969		Cedar Hill Cemetery		Suitland, Maryland			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Warner E. Pumphrey, Inc.		MAR 20 1969		James Judge					

TO : SAC, NEW YORK (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04055									
04051									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Robert T			J	Dannemiller		Month 3 Day 17 Year 69			10 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male		White		JUNE 4-84		84 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
OHIO		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Wheaton			Nursing Home			Merchandise Broker			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MD.			Mont.		Rockville		YES		11101 Waycroft Way
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
AGUSTUS					Dannemiller	Julia			Phierry
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
No			unknown			Wife Mrs A D A B. Dannemiller			11101 Waycroft Way
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Coronary heart failure</u>									3 mos
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u>									20 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>12/13, 1968</u> , to <u>3/17, 1969</u> , that (I) (we) last saw the deceased alive on <u>3/15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u> MD DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/17/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>H F Kreuzburg</u>						22e. ADDRESS <u>7852 16th NW Wash DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			3-20-69		St. John's Cemetery		Canton, Ohio		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY, Bethesda, Maryland						MAR 24 1969		<u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) HANNAH D. DAVIS						2a. DATE OF DEATH March Month 17 Day 1969				2b. HOUR M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 7, 1870			6. AGE (In years lost birthday) 98 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.						
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cedar Haven			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Allegany				13c. CITY OR TOWN Midland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
14. FATHER'S NAME First John Middle Boor Last Boor				15. MOTHER'S MAIDEN NAME First Delilah Middle Baker Last Baker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Irene Hardaway, Bethesda, Md. 20014						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arthritis and arterial hypertension 715X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Age DUE TO, OR AS A CONSEQUENCE OF (c) Age										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Indefinite		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on Mar. 16, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE A.B. Little MD DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED Mar. 17, 1969						
22d. PHYSICIAN'S NAME (Type) A.B. Little		22e. ADDRESS 6911 5th St NW Washington, DC										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 20, 1969		23c. NAME OF CEMETERY OR CREMATORY Fbg. Memorial Park			23d. LOCATION (City or Town) (County) (State) Frostburg, Md.					
24. FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md. 21532				25a. REC'D BY REGISTRAR MAP 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge						

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY STATE DEPARTMENT OF HEALTH										05588	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04060 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
Robert		William		DECKER				Month Day Year		4:30 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	Cau	June 14, 1947		21 YRS		MONTHS DAYS HOURS MIN		Month Day Year		4 10 69 1:10 P.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Mo.	
Indiana		U.S.A.				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Bethesda Naval Hospital				USN					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		T.C.		CHEVERLY				5504 Newton Apt #II			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Wayne		Loyal		DECKER				Marjorie		LaVon Boze	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		WIFE ADDRESS					
Yes		(If yes give war or dates of service)		364 48 9050		LINDA M. G. DECKER		212 No Summit St		XPSILANTI MICH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>Asphyxiation due to drowning</u> 8300 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 4:30 P.M. Mar. 29 1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 21c) Decased drowned when boat capsized in / Potomac River			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Potomac River near Brickyard Road,				21f. LOCATION Street or R.F.D. No. City or Town County State Potomac, Montgomery Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden REAP</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) Belden REAP, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				11 April 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation				4-12-69		Fort Lincoln Crematory		Washington D.C.			
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
1400 Chapin St., N.W. Washington, D.C.						APR 18 1969		J. Charles Judge			

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UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

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DEPARTMENT

OF AGRICULTURE

WASHINGTON

June 1, 1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A		
Michael			Clay		DeMerrell	March 10 1969			10:00		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		White		17 April 1966		2 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Md.					
South Carolina		USA				Montgomery					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			The Clinical Center			None					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Virginia			Fairfax		Alexandria		YES		7131 Richmond Highway		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
George			Stephan		DeMerrell	Patricia					Clay
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT The Medical Records Address						
No			None		The Clinical Center, NIH, Bethesda, Md. 20014						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neuroblastoma</u> <u>1925</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from <u>31 Dec.</u> , 19 <u>68</u> , to <u>10 March</u> , 19 <u>69</u> , that (X) (we) lost saw the deceased alive on <u>10 March</u> , 19 <u>69</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE <u>John S. Sargent, M.D.</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10 March 1969				
22d. PHYSICIAN'S NAME (Type) John S. Sargent, M. D.					22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Cremation		3/11/69		Ft. Lincoln Crematory		Prince Georges County					
24. FUNERAL DIRECTOR The S.H. Hines Company					ADDRESS 2901 14th St. N.W.		25a. REGD. BY REGISTRAR MAR 13 1969		25b. REGISTRAR'S SIGNATURE Md.		
					Washington, D.C.						

12040

CERTIFICATE OF DEATH

12040

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

11. Name of informant: [illegible]
12. Address of informant: [illegible]
13. Signature of informant: [illegible]
14. Date of completion: [illegible]
15. Registrar's Office: [illegible]
16. County: [illegible]
17. State: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M . 1

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <i>Infant</i> First <i>Unborn</i> Middle Last						2a. DATE OF DEATH Month <i>3</i> Day <i>8</i> Year <i>69</i>			2b. HOUR <i>5:30</i> M			
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>3/8/69</i>			6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.						
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Shawmut</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Shawmut</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>16 Manchester Place</i>			
14. FATHER'S NAME First Middle Last <i>Robert Unborn</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Christine C. Langin</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or (unknown)				16b. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mother</i>			Address <i>same</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <i>Perinatal asphyxia of placenta entanglement?</i>												
DUE TO, OR AS A CONSEQUENCE OF <i>Immaturity</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>John J. Kuhn</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>4/10/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>John J. Kuhn</i>						22e. ADDRESS <i>4405 E. West Noyes</i>						
23a. BURIAL (CREMATION) REMOVAL (Specify)			23b. DATE <i>3/11/69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Shawmut Hospital</i>			23d. LOCATION (City or Town) (County) (State) <i>Bethesda - Montgomery - Md.</i>			
24. FUNERAL DIRECTOR <i>Mrs. Amelia C. Carter, Administrator</i>						25a. REC'D BY REGISTRAR DATE <i>APR 13 1969</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

04063

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the document.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04063									
CERTIFICATE OF DEATH									
04055									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Alice Loretta DeSpain						Month Day Year 3 5 69			8 40 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
Female		white		9-14-79			89 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Iowa		USA					Montgomery Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Tahoma Park		Washington Sanatorium-Hospital							
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6141 Tuckerman Lane	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Isaac Armstrong			Maria McCallister						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> or unknown <input type="checkbox"/>			16b. SOCIAL SECURITY NO.		17. INFORMANT				
(If yes give war or dates of service)			219-54-9288		Records - Washington San + Hosp. -				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>4369</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aortic Process</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u> <u>Years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Uremia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <u>Refused</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>3-3</u> , 19 <u>69</u> , to <u>3-5</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3-5-69</u> , 19 <u>69</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>John L. Ford MD</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3-5-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>JOHN L. FORD</u>					22e. ADDRESS <u>831 UNIVERSITY BLVD E SILVER SPRING, MD</u>				
23a. BURIAL, CREMATION, REVIEW (Type)		23b. DATE <u>3/7/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pilot Grove</u>			23d. LOCATION (City or Town) (County) (State) <u>Williamsburg, Iowa</u>		
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>					ADDRESS <u>1531 Rock Pike</u>		25a. REC'D BY REGISTRAR <u>MAR 11 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
					Rockville, Maryland				

04083

RECEIVED

04083

[Faint, illegible handwriting on lined paper]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
04064									
04056									
1. DECEASED-NAME (Type or print) <i>George Russell Devine</i>			2a. DATE OF DEATH Month <i>28</i> Day <i>69</i> Year			2b. HOUR <i>6:30</i> M			
3. SEX <i>male</i>		4. RACE <i>Caus.</i>		5. DATE OF BIRTH <i>5-25-1900</i>		6. AGE (In years lost birthday) <i>68</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Washington DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery County</i> Md.			
10. CITY OR TOWN OF DEATH <i>Wheaton, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Gen. Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Painter</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>WASH. DC</i>		13c. CITY OR TOWN <i>WASH. DC</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1126 11th St. N.W. Wash. DC</i>	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <i>579-03-9458</i>		17. INFORMANT <i>Mrs. Devine</i>		Address <i>1126 11th St. N.W. WASH. D.C.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic secondary to multiple</i> <i>7070</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Stroke</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Poisoning</i>									
19a. DATE OF OPERATION <i>3/28/69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2/13</i> , 19 <i>69</i> , to <i>3/28</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/28</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Myron L. Jenkins</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/28/69</i>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3-31-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Landover Md</i>			
24. FUNERAL DIRECTOR <i>Kallins Funeral Home Inc. 4339 Hunt</i>				ADDRESS		25a. REC'D BY REGISTRAR <i>APR 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

50020

8531 1 29A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04065 Item#54, FilmGh11 4/7/69 km										
04057										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last					2a. DATE OF DEATH Month Day Year			2b. HOUR		
Benjah Catherine DeWane					March 26, 1969			4:22 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
female		white		7-21-1911		58 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Wisconsin		U. S. A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban Secretory			Secretary		Govt.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Montgomery		Cherry Chase				37041 - Stewart St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
UNKNOWN			Pearl Paige							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no			578-22-6887		Harold J. DeWane		3 and 1/2 block			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Myocardial infarction										
4109 DUE TO, OR AS A CONSEQUENCE OF										
(b) coronary artery disease										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
None										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4/6, 1969, to present 1969, that (I) (we) saw the deceased alive on 3/2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John B. Umhau					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/28/69			
22d. PHYSICIAN'S NAME (Type) JOHN B. UMHAU					22e. ADDRESS 8805 Conn. Ave. Chevy Chase, MD					
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL <input type="checkbox"/> (Specify)		23b. DATE 4-1-69		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lake Geneva, Wisconsin				
24. FUNERAL DIRECTOR Robert A. Pumphrey					25a. APR 3 1969 BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
7557-Wisconsin Ave., Bethesda, Md.					DATE					

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ASTOR LENOX TILDEN FOUNDATION
500 5TH AVENUE NEW YORK 17, N.Y.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04066

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Arthur Beers Dickinson			2a. DATE OF DEATH Month 3 Day 19 Year 69			2b. HOUR 6:45 A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-4-94		6. AGE (In years lost birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Conn.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8521 Garland Avenue	
14. FATHER'S NAME First Middle Last Edward M. Dickenson			15. MOTHER'S MAIDEN NAME First Middle Last Fanny Beers						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes WWI		16b. SOCIAL SECURITY NO. 032-16-4500		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Benign prostatic hyperplasia									
19a. DATE OF OPERATION 18 March 69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Retroperic prostatectomy			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 16, 1969 , to March 19, 1969 , that (I) (we) last saw the deceased alive on 18 March 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Henry M. Wise, Jr. MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 19 March 69			
22d. PHYSICIAN'S NAME (Type) HENRY M WISE, JR.				22e. ADDRESS 1111 Spring St, Silver Spring					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/24/69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc.		24b. ADDRESS 8434 Georgia Avenue		25a. REC'D BY REGISTRAR MAR 28 1969		25b. REGISTRAR'S SIGNATURE William J. Indar			

86008

STATE OF TEXAS
COUNTY OF DALLAS

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at the City of Dallas, Texas, this 1st day of May, 1908.

Notary Public in and for the State of Texas

My Commission Expires May 1, 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
MARGARET M DIMAIO						Month Day Year			8:46 AM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE	WHITE		8/2/94			77 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH
Brooklyn, N.Y.			U.S.A.						MONTGOMERY Md.
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING			WHEATON NURSING HOME			housewife			AT HOME
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
MARYLAND			MONTGOMERY			SILVER SPRING			13e. STREET AND NUMBER
									11317 COLLEGE VIEW, DR.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Phillip Karl			Marie Hoelinfeld						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			90 Address
No			158-07-5148A			ARTHUR DIMAIO			90 T. VERNON AVE. IRVINGTON, N.J.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebro Vascular Accident									6 HRS
DUE TO, OR AS A CONSEQUENCE OF									
(b) Arteriosclerosis									8 YRS
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
NONE									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. Month Day Year						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1960, 19, to 3/4, 1969, that (I) (we) last saw the deceased alive on 3/4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Henry W. Stout M.D.								3/8/69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
HENRY W STOUT MD						10011 GEORGIA AVE SILVER SPRING MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL			3-11-1969		HOLLYWOOD MEMPK CEM		UNION, N.J.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. Chambers Co 1400 Chapin St NW, Wash DC						MAR 12 1969		J. J. Judge	

10-11-60

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

STATE OF TEXAS

78020

10-11-60



10-11-60

10-11-60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04068		CERTIFICATE OF DEATH						04060		
1. DECEASED-NAME (Type or print) <i>VERA</i>			First <i>Montros</i>			Middle <i>Dixon</i>			20. DATE OF DEATH 3 Month 5 Day 69 Year	
3. SEX <i>Fe</i>		4. RACE <i>Col</i>		5. DATE OF BIRTH <i>5/2/1893</i>			6. AGE (In years lost birthday) <i>75</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
70. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			Md.	
10. CITY OR TOWN OF DEATH <i>Wheaton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>University Nursing Home</i>			120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Maid</i>			12b. KIND OF BUSINESS OR INDUSTRY	
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>			13b. COUNTY <i>D.C.</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>711 Rhode Island Ave. NW</i>	
14. FATHER'S NAME <i>Unknown</i>			15. MOTHER'S MAIDEN NAME <i>Unknown</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>577-68-6903</i>			17. INFORMANT <i>Yvonne Joyner</i>			Address <i>714 R.I. Ave. N.W. Washington, D.C.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>hypostatic pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>generalized arteriosclerosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>chronic</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>decubitus ulcers</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>3/15</i> , 19 <i>69</i> , to <i>3/18</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/15</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>David P. Morawitz MD</i>			22c. DATE SIGNED <i>3/18/69</i>			22d. PHYSICIAN'S NAME (Type) <i>David P. Morawitz MD</i>			22e. ADDRESS <i>4359 N. Woodlawn Ave. N.E. Washington, D.C.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE <i>3-10-69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>			23d. LOCATION (City or Town) (County) (State) <i>Bladensburg, D.C. N.E.</i>	
24. FUNERAL DIRECTOR <i>James L. Perry</i>			250. REC'D BY REGISTRAR <i>Charles Judge</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			DATE <i>MAR 11 1969</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Meyer</i>			First Middle Last <i>Holinsky</i>			2a. DATE OF DEATH Month Day Year <i>3 25 69</i>			2b. HOUR <i>5:52 PM</i>		
3. SEX <i>m.</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>Aug. 12-1914</i>		6. AGE (In years last birthday) <i>54 YRS.</i>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 2 YRS. HOURS MIN	
7a. PLACE (State or foreign country) <i>Lower</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Chemist Ford & King Arms</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>				13b. CITY OR TOWN <i>Montgomery</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>10005 Baltimore Road</i>			
14. FATHER'S NAME First Middle Last <i>Isaac Holinsky</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Unk.</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes, give war or dates of service) <i>WW II Army</i>				16b. SOCIAL SECURITY NO. <i>356-09-6413</i>		17. INFORMANT <i>Wesley Holinsky</i>				Address <i>same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary arteriosclerosis with thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>4 days</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>3/25, 1969</i> , to <i>5/25, 1969</i> , that (I) (we) last saw the deceased alive on <i>5/25, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Robert R. Montgomery</i>						22c. DATE SIGNED <i>3/26/69</i>					
22d. PHYSICIAN'S NAME (Type) <i>ROBERT R. MONTGOMERY</i>						22e. ADDRESS <i>5411 CEDAR LANE BETHESDA, MD.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE <i>3-27-1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>NATIONAL MEMORIAL PARK</i>			23d. LOCATION (City or Town) (County) (State) <i>FALLS CHURCH VA.</i>		
24. FUNERAL DIRECTOR <i>GOLDSTEIN FINE & HARRIS 4217 9TH ST. N.W.</i>						25a. APR 1 1969 BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			2b. HOUR
Florence H. Donaldson						Month Day Year			2:30 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	2d. HOUR
Female	White	3/16/78	91 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	2:30 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Mo.
Mass.		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			Holy Cross			Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	
Md.			Mont. Co.		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	410 Ednor Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
HAMDEN ERTON			SARAH DEABOY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown <input type="checkbox"/>			NONE		EDWIN R. DONALDSON		410 EDNOR RD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Acute Hemorrhagic Nephrositis									
5770 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Intestinal Bleeding - Diverticulosis									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. P.M.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Belden R. Keap						MARCH 23, 1969			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER						
Belden R. Keap									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Cremation			3-25-1969		Ft. Lincoln Cemetery		Columbia Manor Md		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. W. Chambers Co.			1400 Chapin St. N.W. Wash D.C.			MAR 28 1969		W. W. Chambers	

05030

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Cause of Death	
Occupation		Manner of Death	
Signature of Medical Examiner		Signature of Coroner	
Date of Examination		Time of Examination	
Place of Examination		City and County	
State		Federal District	

FILED

RECEIVED
DEPARTMENT OF HEALTH
ALBANY, N.Y.
JAN 10 1930

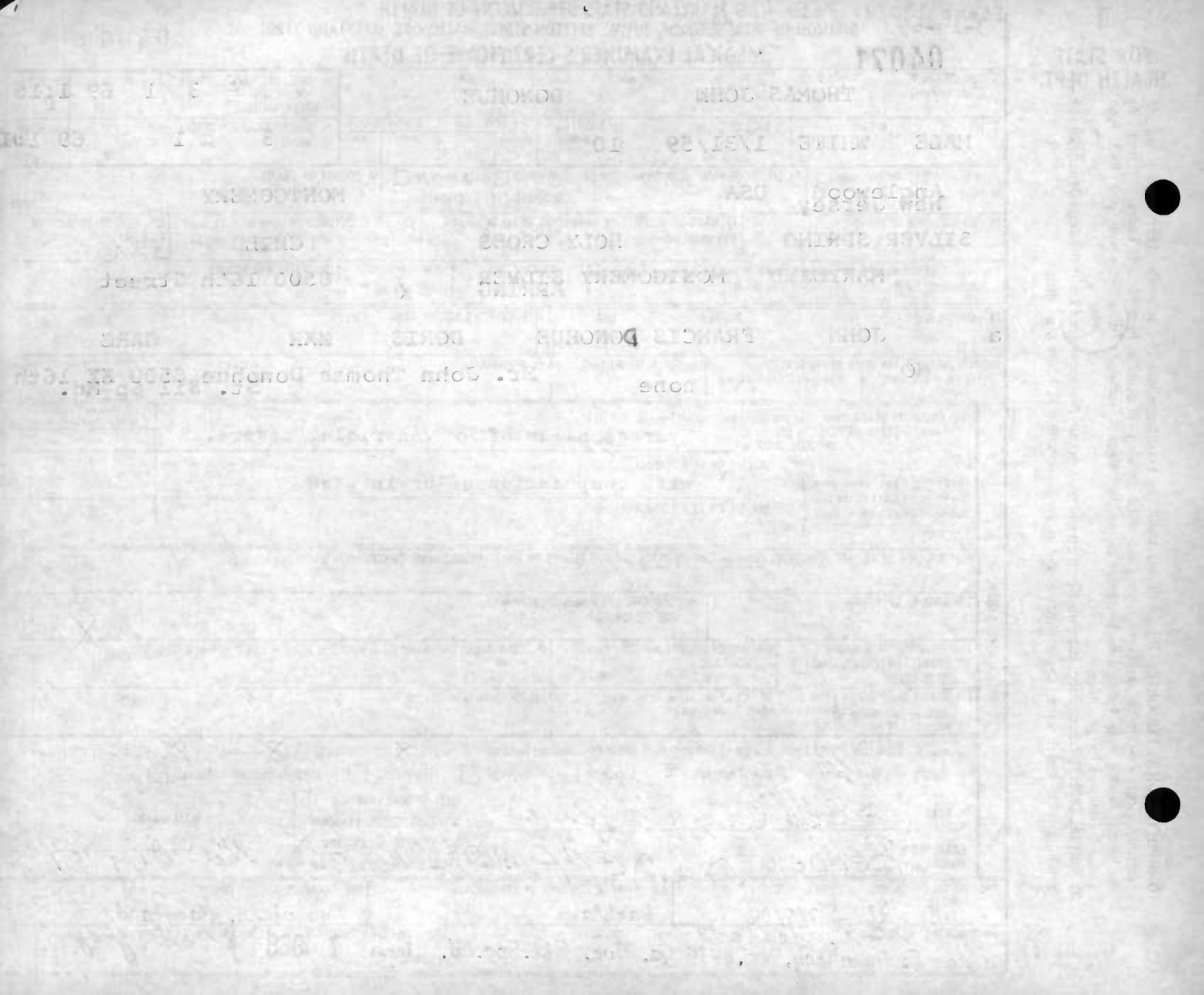
04071

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

VR A15ME (5)
10M REV. 1/68

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is unnecessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/68

04072		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04064					
1. DECEASED-NAME (Type or print) First Middle Last EWEUL L Dooley						2a. DATE OF DEATH Month Day Year March 16 1969			2b. HOUR 11:40 P.M.		
3. SEX male		4. RACE white		5. DATE OF BIRTH 9/30/1894		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Miss.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 199 Collins Ave. Apt-31					
14. FATHER'S NAME First Middle Last Thomas William Dooley				15. MOTHER'S MAIDEN NAME First Middle Last Mollie Simm Davis				Address 1318 Emily St Kensington, Md			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or <u>unknown</u>		16b. SOCIAL SECURITY NO. 431-58-9685		17. INFORMANT Woodrow Tobley		Address 1318 Emily St Kensington, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterior Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>?</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 16</u> , 19 <u>69</u> , to <u>Mar 16</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Mar 16</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE George Sharpe MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/17/69			
22d. PHYSICIAN'S NAME (Type) George Sharpe MD				22e. ADDRESS 10400 Conn. Ave. Kensington, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-19-69		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville Mont. Md					
24. FUNERAL DIRECTOR Robert A Pumphrey				ADDRESS 7557 Wisconsin Ave Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 24 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones			

05040

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Attended with Medical Examiner - 584

04073												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												04065																							
Item 2a Film 411 4/15/69 kk												CERTIFICATE OF DEATH																																			
1. DECEASED-NAME (Type or print) James						First John						Middle Douglas						Last Douglas						2a. DATE OF DEATH Month 3 Day 24 Year 69						2b. HOUR 2:30 AM																	
3. SEX Male						4. RACE White						5. DATE OF BIRTH 2-16-12						6. AGE (In years last birthday) 57 YRS.						IF UNDER 1 YEAR MONTHS DAYS						IF UNDER 24 HRS. HOURS MIN.																	
7a. BIRTHPLACE (State or foreign country) Pennsylvania						7b. CITIZEN OF WHAT COUNTRY? U.S.A.						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. COUNTY OF DEATH Montgomery Md.																													
10. CITY OR TOWN OF DEATH Silver Spring						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales						12b. KIND OF BUSINESS OR INDUSTRY Carpets																													
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.						13b. COUNTY Montgomery						13c. CITY OR TOWN Sil. Spr.						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET AND NUMBER 11215 Oakleaf Dr. S.S. Md.																							
14. FATHER'S NAME John						First ?						Middle Douglas						Last Douglas						15. MOTHER'S MAIDEN NAME Katherine						First ?						Middle Dunn						Last Dunn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No						(If yes give war or dates of service)						16b. SOCIAL SECURITY NO. 173-09-3288						17. INFORMANT Mrs. Margaret Colony - 9243 Greenwood La.												Address Lanham, Md.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS. ? YEARS.																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work						21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State																																			
22a. I certify that (I) (this hospital) attended the deceased from October , 19 67 , to March 23 , 19 69 , that (I) (we) last saw the deceased alive on January , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																															
22b. SIGNATURE Dr. G. Graziani MD, DEGREE												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 3/24/69																													
22d. PHYSICIAN'S NAME (Type) HUGO G. GRAZIANI												22e. ADDRESS 10101 GEORGIA AVENUE S.S. MD.																																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE Mar 28, 1969						23c. NAME OF CEMETERY OR CREMATORY St. Josephs						23d. LOCATION (City or Town) (County) (State) Flemming, N. Y Cayuga County																													
24. FUNERAL DIRECTOR Warner C. Humphrey Inc. 8434												ADDRESS Silver Spring, Md. P. S. Smith						25a. REC'D BY REGISTRAR DATE MAR 28 1969						25b. REGISTRAR'S SIGNATURE [Signature]																							

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21190

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>04074</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>04066</div>											
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
Sara		Louise		Douglass				<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> 3 27 1969		6 A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	2d. HOUR
Fe	W	APR 19, 1919		49 YRS		MONTHS DAYS		HOURS MIN.		March 27 Year 1969	9 A M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
OHIO		U.S.A.		<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				Montgomery		Bethesda	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	
25 Farmington Court						Maryland		Montgomery		Bethesda	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First	
Clinton		C		Hayes				Minnie		Delong	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No		579-05-9095		GEORGETOWN MED. SCH. RECORDS				PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Gun shot wound of Head - 955X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO		<input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home; farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		6? PM 3/27 1969		Shot Self in mouth - 22 cal. Rifle -		25 Farmington Court		Bethesda		Montgomery Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John S. Ball		M.D.		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED		March 27, 1969	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		<input checked="" type="checkbox"/>	
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
REMOVAL		3-28-69		GEORGETOWN UNIV. MED SCH.		WASH. D.C.		APR 1 1969		Charles Judge	
24. FUNERAL DIRECTOR		John S. Ball		ADDRESS		Wash D.C.					

04074

CHIEF OF BUREAU



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04075											
CERTIFICATE OF DEATH											
04067											
1. DECEASED-NAME (Type or print) BURNS			First C. Middle C. Last DOWNEY			2a. DATE OF DEATH 3 Month 30 Day 69 Year		2b. HOUR 6:57 AM			
3. SEX MALE		4. RACE CAUCASION		5. DATE OF BIRTH 11-16-1881		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Cherry Chase			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda Silver Spring Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.			13b. COUNTY WASHINGTON		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4215 BRANDYWINE ST., N.W.				
14. FATHER'S NAME First Calvin Middle W. Last Downey			15. MOTHER'S MAIDEN NAME First Laura J. Middle Collins Last Collins								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b. SOCIAL SECURITY NO. 578-62-0020-T		17. INFORMANT Address ROBT. J. DOWNEY - SAME AS #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4339 IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1960 , 19 3/24/69 , to 3/30/69 , that (I) (we) last saw the deceased alive on 3/24/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles P. Duvall						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-30-69			
22d. PHYSICIAN'S NAME (Type) CHARLES P. DUVAL						22e. ADDRESS 2141 K ST NW					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/3/69		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		23d. LOCATION (City or Town) (County) (State) SUITLAND, MD.					
24. FUNERAL DIRECTOR Sos. GAWLER'S FUNERAL HOME						25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

04032



Charles H. Jones
1871-1872

Charles H. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04076

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04068

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <i>Albert DUGGAN</i>			2a. DATE OF DEATH <i>March 22 1969</i> Month Day Year		2b. HOUR <i>12:35 A.M.</i>			
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>August 1 1883</i>		6. AGE (In years last birthday) <i>85</i> YRS. MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Silver Spring, Maryland</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Colonial Hills Nurs. Home 12325 New Hope Ave.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>machinist</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>fire dept</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>P. G.</i>		13c. CITY OR TOWN <i>Laurel</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last <i>unknown</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>unknown</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown			17. INFORMANT <i>James Duggan, Laurel Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Congestive Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arterio-sclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>severe generalized arterio-sclerosis</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 years</i> <i>10 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Fracture Right femoral neck (old.)</i>								
19a. DATE OF OPERATION <i>8-20-68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>R. Rt. Femoral neck</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>8 19 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fell in nursing home</i>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>Fairland Nursing Home</i>		21f. LOCATION Street or R.F.D. No. City or Town County State <i>Fairland Nursing Home Silver Spring Md</i>				
22a. I certify that (I) (this hospital) attended the deceased from <i>8-19-1968</i> to <i>3-21-1969</i> , that (I) (we) last saw the deceased alive on <i>3-21-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Herbert S. Gates M.D.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-22-69</i>		
22d. PHYSICIAN'S NAME (Type) <i>819 E. Cap. St. HERBERT S. GATES M.D.</i>				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>3-25-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ST LAWRENCE CEM</i>		23d. LOCATION (City or Town) (County) (State) <i>CHARLESTON S. CAR</i>		
24. FUNERAL DIRECTOR <i>DONALDSON FUNERAL HOME LAUREL MD</i>				25a. DATE <i>APR 1 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

04036

RECEIVED

Form with horizontal lines and faint text, possibly a ledger or record book. The text is mostly illegible due to fading and bleed-through.

7/10/10 10:30 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04069

04077

1. DECEASED-NAME (Type or print) MRS. GERTRUDE ELKINS			2a. DATE OF DEATH Month MARCH Day 9 Year 69		2b. HOUR 1:15 AM
3. SEX FEMALE	4. RACE CAUCASION	5. DATE OF BIRTH JULY 6, 1901		6. AGE (In years last birthday) 67 (RS.)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) HUNGARY	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH CHEVY CHASE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BETHESDA SILVER SPRING NURSING HOME	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.	13b. COUNTY —	13c. CITY OR TOWN WASHINGTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4000 MASS. AVE. N.W.	
14. FATHER'S NAME First MARTIN Middle MOSKOWITZ Last —		15. MOTHER'S MAIDEN NAME First ROSE Middle — Last —			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) — (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578-30-4400A		17. INFORMANT SAMUEL H. ELKINS, HUSBAND, SAME AS #13 Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 151.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of Stomach DUE TO, OR AS A CONSEQUENCE OF (c) Carcinomatosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 5 mo					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus; Hypertensive heart disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased and saw the deceased alive on 2-8-69 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE B. Manchester		22c. DATE SIGNED 9 Oct 19 69		22d. PHYSICIAN'S NAME (Type) BENJAMIN MANCHESTER	
22e. ADDRESS 206 Spring St NW					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-11-1969		23c. NAME OF CEMETERY OR CREMATORY King David Cemetery	
23d. LOCATION (City or Town) (County) (State) Falls Church, Fairfax Co., Va.					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave.		25a. REC'D BY REGISTRAR MAR 14 1969		25b. REGISTRAR'S SIGNATURE John Judge	

55020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04078									
CERTIFICATE OF DEATH									
04070									
1. DECEASED-NAME (Type or print) First Middle Last Kathy Lynn Erisman					2a. DATE OF DEATH Month Day Year March 19 1969			2b. HOUR A M 2:40 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8 February 1962		6. AGE (In years lost-birthday) 7 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Connecticut		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address) NIH The Clinical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12221 Bluhill Road	
14. FATHER'S NAME First Middle Last Donald B. Erisman			15. MOTHER'S MAIDEN NAME First Middle Last Judith G. Carter						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram-negative septicemia and pneumonia</u> 2040 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute lymphocytic leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 3 5/6 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Meningeal leukemia, seizure disorder, coma of unknown etiology</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6 Jan.</u> , 1969, to <u>19 March</u> , 1969, that (I) (we) lost saw the deceased alive on <u>19 March</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 19 March 1969					
22d. PHYSICIAN'S NAME (Type) Alan L. Snyder, M.D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-24-69		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Va.			
24. FUNERAL DIRECTOR Francis J. Collins		ADDRESS 500 University Blvd. W. Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE APR 24 1969		25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
William Hull EVANS						3 Month 4 Day 69 year		1158 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
Male		Negro		March 6, 1923		45 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Florida		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Drosuenebor Lane Nursing & Conv. Center, 5921 Drosuenebor Lane					Truck driver	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
D.C.			Washington				50 Irving Street, NW		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Willie EVANS			Bydea Beatrice Holmes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
			578-182-503		Mrs. Bydea ESTICK 3603 10th St. N.W. DC				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) asphyxiation pneumonia									
DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma of the tongue									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2/28, 1969, to 3/5, 1969, that (I) (we) last saw the deceased alive on 3/1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
David Morowitz M.D.					3/5/69				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Dr. David Morowitz					5721 Grosvenor La. Bethesda, Maryland				
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
CREMATION		3/10/69		Lincoln Memorial		Suitland PG Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Morrow & Woodford					DATE		MAR 10 1969		

65040

• 1971 Grosvenor, L.A.
to Elmhurst, Ill. by rail

15-00000 15-00000

0001 01822

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Released by Med. Exam. 16 Dr. Paul

MEDICAL CERTIFICATE

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
MICHELLE K. FAGAN					Month Day Year MARCH 24 1969		505 A		
3. SEX	FEMALE		4. RACE	WHITE		5. DATE OF BIRTH	6. AGE (In years last birthday)		
						2/17/69	5 WEEKS YRS.		
7a. BIRTHPLACE (State or foreign country)	Md. - Montgo.		7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
							Montgomery Md.		
10. CITY OR TOWN OF DEATH	Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Holy Cross Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.		13b. COUNTY	Beltsville		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
	LEONARD W.		FAGAN JR	MARGARET P.				RUSSELL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)	(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	17. INFORMANT		Address			
				Leonard W. Fagan Jr		Beltsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pneumonia</u>									
485x DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Bilateral confluent broncho-pneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/13/69, 19, to 3/24/69 19, that (I) (we) last saw the deceased alive on 3/24/69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Stanley H. Steinberg, MD.						3/24/69			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Stanley H. Steinberg						1040 University Blvd Silver Springs, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Mar 25, 1969		Gate of Heaven		Silver Springs Montgomery Md		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE
F. Gasch's Sons Hyattsville, Md.			MAR 27 1969						Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04081

CERTIFICATE OF DEATH

04073

1. DECEASED-NAME (Type or print) MARTHA HENRIETTA FERGUSON			2a. DATE OF DEATH Month Mar. Day 26 Year 1969			2b. HOUR 7 P M	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH Dec. 9, 1885		6. AGE (In years lost birthday) 83 YRS.	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 13314 Okinawa Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 13314 Okinawa Ave.		14. FATHER'S NAME First Julius Middle Marinier Last		15. MOTHER'S MAIDEN NAME First Daug. Middle Tucker Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. 545-38-4080A		17. INFORMANT Mrs. Tucker		17. ADDRESS Same as Item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months 4 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary Artery Disease - No evidence of infarction							
19a. DATE OF OPERATION 11 March 69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Proctostomia		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6 March, 1969 to 20 March, 1969 , that (I) (we) last saw the deceased alive on 20 March 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Eugene P. Libre		DEGREE EUGENE P. LIBRE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 27 March 69	
22d. PHYSICIAN'S NAME (Type) EUGENE P. LIBRE		22e. ADDRESS 10400 Conn. Ave., XXXXX Kensington, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-3-69		23c. NAME OF CEMETERY OR CREMATORY Brighton Cemetery		23d. LOCATION (City or Town) (County) (State) Brighton, Illinois	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE Richard J. Judge	

18030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04082

04074

1. DECEASED-NAME (Type or print) VITA			First	Middle	Last	2a. DATE OF DEATH Month March Day 6 Year 1969			2b. HOUR 6:40 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7-30-81		6. AGE (In years Month Day YRS. 87 birth day)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home					
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1505 Red Oak Dr.			
14. FATHER'S NAME First Frank Middle -- Last DiMisa		15. MOTHER'S MAIDEN NAME First Frances Middle -- Last Spagnuolo									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) ----		17. INFORMANT Address Mrs. Frances Rogers 1505 Red Oak Dr. S.S., Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive & arteriosclerotic CVD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hr. 2 yrs. 10 yrs.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (this hospital) attended the deceased from Mrs. , 19 68 , to Mrs. b. , 19 69 , that (we) lost saw the deceased alive on Mrs. 5 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. D. Bauer MD.		DEGREE MD.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-7-69					
22d. PHYSICIAN'S NAME (Type) R. D. Bauer, MD.		22e. ADDRESS 2513 Bucklodge Rd. Rockville, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/10/69		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D.C.				
24. FUNERAL DIRECTOR Joe. Gawler's Sons, 5130 Wis. Ave. N.W. Washington, D.C.					25a. REC'D BY REGISTRAR DATE MAR 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

04081

CERTIFICATE OF DEATH

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04083

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04075

FOR STATE
HEALTH DEPT.

1. DECEASED-NAME (Type or Print) Mary Ann Flores			2a. DATE KNOWN OF DEATH Month 3 Day 24 Year 69			2b. HOUR 8:30 AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH 3-8-35	6. AGE (In years last birthday) 34 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 3 Day 24 Year 69	
7a. BIRTHPLACE (State or foreign country) New Mexico		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Analyst		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Patrick Flores		15. MOTHER'S MAIDEN NAME Delia Flores		13e. STREET AND NUMBER 5608 Whitfield Chapel Rd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. Hosp chart		17. INFORMANT Hosp chart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive, acute, cerebral hemorrhage 4309 DUE TO, OR AS A CONSEQUENCE OF (b) due to Ruptured Berry Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year _____. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 3/24/1969	
EXAMINER'S NAME (Type) BELDEN R. REAP		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city or town or county) Washington D.C.			
23a. BURIAL-CREATION, REMOVAL (Specify) Interment		23b. DATE March 29-1969		23c. NAME OF CEMETERY OR CREMATORY Sierra Vista		23d. LOCATION (City or Town) (County) (State) Laurel Prince Georges Maryland	
24. FUNERAL DIRECTOR Laurel Funeral Home Inc		ADDRESS 254 Carroll St. N.W.		25a. REC'D BY REGISTRAR DATE 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04083

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on or in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04084											
CERTIFICATE OF DEATH											
04076											
1. DECEASED-NAME (Type or print) <i>Dorothy</i>			First <i>H.</i> Middle <i>Fluent</i> Last			2a. DATE OF DEATH Month <i>March</i> Day <i>3</i> Year <i>1969</i>		2b. HOUR <i>9:05 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>April 3, 1898</i>		6. AGE (In years lost birthday) <i>70</i> YRS.		IF UNDER 1 YEAR MONTHS <i>11</i> DAYS <i>2</i> HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>Maine</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross of Silver Spring</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Rockville, Md. 4710 Kemper Street</i>			
14. FATHER'S NAME First <i>Walter</i> Middle <i>Hall</i> Last			15. MOTHER'S MAIDEN NAME First <i>Annie</i> Middle <i>Hall</i> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>004-186-6299</i>		17. INFORMANT <i>Mr. Roger E. Bucklin</i>		Address <i>4710 Kemper Street Rockville, Maryland</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension with extension</i> <i>1890</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>into right Atrium</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>3-3-66</i> to <i>3-3-69</i> , 19 <i>66</i> to <i>3-3-69</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3-3-69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>(did)</i> (did not) view the body after death.											
22b. SIGNATURE <i>G. B. Cushman</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-4-69</i>					
22d. PHYSICIAN'S NAME (Type) <i>Gilbert B. Cushman</i>		22e. ADDRESS <i>11161 New Hampshire Ave., Silver Spring</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>March 6, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Bladensburg, Maryland</i>					
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 10 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Items 18, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04085

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04077

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year		2b. HOUR
JOHN BASIL FORBES SR					OF ESTI- DEATH MATED <input type="checkbox"/> 3 21 1969		10:27 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7c. DATE PRONOUNCED DEAD		2d. HOUR
MALE	WHITE	7/23/21		47 YRS	MARCH 21 1969		10:27 AM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
NEW YORK		U.S.A.				MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		SUBURBAN		ENGINEER			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
MARYLAND		MONTGOMERY		ROCKVILLE		1609 BRADLEY AVE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.	
ROV		ADA M VAN		NAVY		180-12-8174	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction old + Recent - DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Arterio Sclerosis - DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED March 22, 1969			
ACTUAL SIGNATURE John G Ball		EXAMINER'S NAME (Type) John G Ball		ADDRESS (Street, city, town, or county) 7936 Old Georgetown Rd			
23a. BURIAL, CREMATION, REMOVAL, SPECIFY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		3-25-69		Baltimore National		Baltimore Maryland	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A Pumphrey		7557 Wisconsin Ave Bethesda, Md		MAR 26 1969		[Signature]	

22020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

04086		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04078		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print) <i>Amy</i>			First <i>L</i>	Middle <i>FORD</i>	Last	2a. DATE OF DEATH Month <i>March</i> Day <i>5</i> Year <i>1969</i>		2b. HOUR <i>7:30</i> M
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2/18/86</i>		6. AGE (In years last birthday) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Shop</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>DC</i>		13b. COUNTY <i>13b. COUNTY</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3254 (Washington St NW</i>
14. FATHER'S NAME First <i>George</i> Middle <i>Sheen</i> Last <i>Jennie</i>			15. MOTHER'S MAIDEN NAME First <i>Jennie</i> Middle <i>Buckley</i> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT <i>ELVA H. Tyler - 3254-Washington St N.W.</i>			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia, severe</i> <i>403X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Nephrosclerosis & renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis severe & hypertension</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-4 days?</i> <i>undet.</i> <i>5 yrs +</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>St. hemiplegia, severe bald I General exanthema dermatitis</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1969</i> , to <i>3-5-1969</i> , that (I) (we) lost the deceased on <i>3-4-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.								
22b. SIGNATURE <i>Stewart Clapp MD</i>		22c. DATE SIGNED <i>March 5 1969</i>		22d. PHYSICIAN'S NAME (Type) <i>Stewart Clapp MD</i>				
22e. ADDRESS <i>5415 W. Cedar Lane Bethesda Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Mar 7-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Natl. Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>		
24. FUNERAL DIRECTOR <i>Simmons Bros</i>		ADDRESS <i>Wash DC</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
26. ADDRESS <i>Simmons Bros 1661-Good Hope Rd SE</i>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04087					04079				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
First Middle Last EDWARD JACKSON FOX					Month Day Year March 15 1969				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7b. HOUR	
Male		White		8-31-95		73 YRS.		8:55 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park			Washington San. & Hospital			Retired Chemist			Dept. of Agriculture
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland			Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		112 Revere Place
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last William Pierce Fox			First Middle Last Mary Ellen Digges						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes, no, or unknown Yes			WWI		Mrs. Grace Fox 112 Revere Pl., S.S., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>arteriosclerotic Heart Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work									
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>54</u> , to <u>March 15</u> , 19 <u>69</u> , that (I) (was) lost saw the deceased alive on <u>March 14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
<u>Russell B. Arnold</u>									<u>3/15/69</u>
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
<u>Russell B. Arnold MD.</u>					<u>1106 Spring Street, Silver Spring, Md. 20910</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
<u>Burial</u>		<u>Mar 18, 1969</u>		<u>St. Lincoln</u>			<u>Bladensburg, Md.</u>		
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
<u>P. Smith</u>					<u>Warner E. Pumphrey Inc. 8434 Ga. Ave. Silver Spring, Md.</u>		DATE <u>MAR 20 1969</u>		<u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 411 4-7-69																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
04088																	
CERTIFICATE OF DEATH																	
04080																	
1. DECEASED-NAME (Type or print)			First Richard			Middle Vogeli			Last FOX			2a. DATE OF DEATH March Month 25 Day 69 Year			2b. HOUR 930A ^M		
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH September 18, 1931			6. AGE (In years last birthday) 37 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS.		
7a. BIRTHPLACE (State or foreign country) Indiana			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			Md.					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U. S. Navy			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia			13b. COUNTY Fairfax			13c. CITY OR TOWN Alexandria			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 6315 Landess St.					
14. FATHER'S NAME Guy			First K.			Middle FOX			15. MOTHER'S MAIDEN NAME Helen			First Vogeli			Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> (If yes, give year or date of discharge) 1953-1969			16b. SOCIAL SECURITY NO. 309 34 3043			17. INFORMANT Navy Records			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis (Primary site not yet determined)</u> 1541 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of rectum with metastases</u> (c) <u>Unknown</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 7</u> , 19 <u>69</u> , to <u>March 25</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>March 25</u> , 19 <u>69</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>D. W. Shea M.D.</u>			DEGREE M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 25 March 1969								
22d. PHYSICIAN'S NAME (Type) D. W. SHEA, M. D.			22e. ADDRESS Naval Hospital, Bethesda, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3-29-69			23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery			23d. LOCATION (City or Town) (State) Evansville Ind.								
24. FUNERAL DIRECTOR W. W. Chambers Co.			ADDRESS 1400 Chapin Street, N.W., Washington, D. C.			25a. REC'D BY REGISTRAR MAR 28 1969			25b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED WITH MEDICAL EXAMINER'S SIGNATURE

04089		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04081			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
ARDATH		6		FRANTZ	3 Month 23 Day Year 69		6 20 P M		
3. SEX	F	4. RACE	W	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
				SEPT 10 18 89		79 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
Maryland		USA				MONTGOMERY		SILVER SPRING	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
SYLVAN MANOR HOME		NURSING HOME		Government					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
D.C.		Montgomery		Silver Spring				1375 - Campden St.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
6. M.		Cale			Frances		Lapp		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		1512 - LIVE OAK DR. SILVER SPRING MD.			
No				FRANK FRANTZ					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebrovascular Accident								1 HR	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Arteriosclerosis									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
NONE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8/5, 1963, to 3/23, 1969, that (I) (we) last saw the deceased alive on 2/26, 1964, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS
Henry Stout MD		3/23/69		HENRY W. STOUT					16011 GEORGIA AVE SILVER SPRING MD
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb 26 - 1969		Camp Ground		Baltimore			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John Stoll		MAR 27 1969		John Stoll					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04090

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) George W FReas			2a. DATE OF DEATH Month 3 Day 26 Year 1969			2b. HOUR 6:37 PM	
3. SEX male		4. RACE white		5. DATE OF BIRTH 5-6-96		6. AGE (In years last birthday) 72 YRS.	
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY CO. Md.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Adm. Asst. of Defense		12b. KIND OF BUSINESS OR INDUSTRY Dept.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md. D.C.		13b. COUNTY Washington D.C.		13c. CITY OR TOWN WASHINGTON D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 321 ASPEN ST.		13f. N.W.					
14. FATHER'S NAME First Levi Middle Freas Last Freas			15. MOTHER'S MAIDEN NAME First Elizabeth Middle Menze Last Menze				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown YES (If yes give war or dates of service) 1917-1918		16b. SOCIAL SECURITY NO. 579-09-4905A		17. INFORMANT (Wife) Address Mrs. Helen O. Freas 321 Aspen St., N.W., D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelofibrosis - Atypical Lymphoma DUE TO, OR AS A CONSEQUENCE OF (b) Gram negative sepsis (clinical) DUE TO, OR AS A CONSEQUENCE OF (c) Myeloproliferative disorder manifest as Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 209X							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) (R) A-K amputation for cellulitis + necrosis							
19a. DATE OF OPERATION 1 March 1969		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 15 Jan 1969 , to 20 March 1969 , that (I) (we) lost saw the deceased alive on 26 March 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Eugene P. Libre		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 27 March 1969	
22d. PHYSICIAN'S NAME (Type) Eugene P. Libre		22e. ADDRESS 10400 Connecticut Ave., Kensington, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 29, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Avenue		25a. REC'D BY REGISTRAR APR 1 1969	
						25b. REGISTRAR'S SIGNATURE Francis Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04091

04083

1. DECEASED-NAME (Type or print) FRANK Celia L. FRUND			2a. DATE OF DEATH Month 3 Day 8 Year 69			2b. HOUR 3:10 4 M			
3. SEX F		4. RACE W		5. DATE OF BIRTH June 20, 1885		6. AGE (in years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Murray, Minnesota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chey Chase Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 13b. COUNTY 2603 Glenallen Ave., Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 2603 Glenallen Ave.,			
14. FATHER'S NAME First James Middle Smith Last Smith			15. MOTHER'S MAIDEN NAME First Eleanor Middle McBreen Last McBreen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Eleanor McBreen, 13 a, b, c, d, e above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease and DUE TO, OR AS A CONSEQUENCE OF (c) rheumatoid arthritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 d. 3 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Rheumatoid arthritis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 1965 , to March 8, 1969 , that (I) (we) last saw the deceased alive on March 7, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dorothy Gill, M.D.				22c. DATE SIGNED March 7, 1969					
22d. PHYSICIAN'S NAME (Type) Dorothy Gill				22e. ADDRESS 7511 Arlington Rd., Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11 Mar. 1969		23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION (City or Town) (County) (State) Springfield, Illinois			
24. FUNERAL DIRECTOR Rinaldi Funeral Home				24b. ADDRESS 7400 Georgia Ave., NW		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
24c. ADDRESS Washington, DC 20012				25a. DATE MAR 11 1969					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04092		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04084			
1. DECEASED-NAME (Type or print) First Middle Last CARON (No MIDDLE) FULTON						2a. DATE OF DEATH Month Day Year 3 3 69		2b. HOUR 7 05 P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 3/12/1867		6. AGE (In years last birthday) 101 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NSG & CONVALESCENT CENT		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5303 Pooks Hill Road	
14. FATHER'S NAME First Middle Last HENRY FULTON		15. MOTHER'S MAIDEN NAME First Middle Last LETTICE PANCOSTE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) NO		16b. SOCIAL SECURITY NO. 284-24-3971		17. INFORMANT Address ANN BRONSON 5303 POKS HILL RD, BETH MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Rectum</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Rectum</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos. 6 mos.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Nov 1965, to March 3, 1969, that (I) (we) last saw the deceased alive on March 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John D. Herman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED MARCH 3, 1969			
22d. PHYSICIAN'S NAME (Type) JOHN D HERMAN				22e. ADDRESS 4801 Montgomery La. Bethesda, md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-7-69		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Montg. Co. Md.			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, md.				25a. REC'D BY REGISTRAR DATE MAR 12 1969		25b. REGISTRAR'S SIGNATURE Alexander Under			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04093

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04085

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last HARVEY NONE GAMBRILL			2a. DATE OF DEATH 3 Month 13 Day 69 Year			2b. HOUR 9:25 P M					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11-28-86		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) TEXAS		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN. & HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STEAM FITTER		12b. KIND OF BUSINESS OR INDUSTRY RETIRED					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY MISTY		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7125 Willow Av.			
14. FATHER'S NAME First Middle Last SAMUEL GAMBRILL			15. MOTHER'S MAIDEN NAME First Middle Last Lillian Ridgeway								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 579-03-814		17. INFORMANT Hospital Records.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 481X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 5 weeks										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Cardiovascular disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1967, 19, to March 13, 1969, that (I) (we) last saw the deceased alive on March 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James M Whitlock					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-13-69				
22d. PHYSICIAN'S NAME (Type) JAMES M WHITLOCK					22e. ADDRESS 7717 Caroline Tamarack and						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE March 17, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) Colmar Manor		(County) (State) Md			
24. FUNERAL DIRECTOR James M Whitlock					ADDRESS 255 Carroll St. x100		REC'D BY REGISTRAR DATE MAR 18 1969		25b. REGISTRAR'S SIGNATURE William J. Judge		

04003

RECEIVED BY MAIL

TO THE DIRECTOR OF THE BUREAU OF THE CENSUS
WASHINGTON, D. C.
FROM THE DIRECTOR OF THE BUREAU OF THE CENSUS
WASHINGTON, D. C.
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or official correspondence.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15ME (5)
10M REV. 1/68

04094		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04086	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or Print) First Middle Last Orem Aquilla Gardner				2a. DATE KNOWN OF DEATH Month 3 Day 24 Year 1969			
3. SEX Male	4. RACE White	5. DATE OF BIRTH 6/15/96 94	6. AGE (in years) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 3 Day 24 Year 1969	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Postmaster		12b. KIND OF BUSINESS OR INDUSTRY Post Office	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Queen Anne		13c. CITY OR TOWN Chester		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last William E Gardner		15. MOTHER'S MAIDEN NAME First Middle Last Virginia Harris					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. WW I 213-22-6476		17. INFORMANT ADDRESS Mrs Virginia Robinson 16215 Woodman Circle S.E. of Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Reap M.D.		22b. DATE SIGNED 3/24/1969		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-24-69		23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery		23d. LOCATION (City or Town) (County) (State) Stevensville Maryland	
24. FUNERAL DIRECTOR 500 University Blvd. W. Silver Spring Md		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

Name		Address		City		State		Country	
John Doe		123 Main St		New York		NY		USA	
Date		Order No.		Product		Quantity		Price	
10/1/19		12345		Apples		100 lbs		\$10.00	
Fruit		Vegetables		Flowers		Seeds		Other	
X		X		X		X		X	
Total		Subtotal		Tax		Shipping		Total	
\$10.00		\$10.00		\$0.00		\$2.00		\$12.00	
Signature		Name		Address		City		State	
John Doe		John Doe		123 Main St		New York		NY	
Date		Order No.		Product		Quantity		Price	
10/1/19		12345		Apples		100 lbs		\$10.00	
Fruit		Vegetables		Flowers		Seeds		Other	
X		X		X		X		X	
Total		Subtotal		Tax		Shipping		Total	
\$10.00		\$10.00		\$0.00		\$2.00		\$12.00	

04095

CERTIFICATE OF DEATH

04087

1. DECEASED-NAME (Type or print)			First Middle Last			20. DATE OF DEATH			2b. HOUR			
Annie			V. Garrett			Month Day Year March 3 1969			6:40 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		Sept. 26, 1875			93 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Virginia		USA					Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park			Park Haven Nursing Home			Housewife			At Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Montgomery		Kensington				3611 Littledale Road			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last Samuel P. Trewolla			First Middle Last Virginia Carter									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address				
No			---		Arthur L. Garrett			Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 1/2 years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 10</u> , 19 <u>66</u> , to <u>March 3</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>March 3</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Neil P. Campbell</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>3/3/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Neil P. Campbell</u>						22e. ADDRESS <u>1629 Columbia Rd.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial		3/6/69		Cedar Hill Cemetery			Suitland			Maryland		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
J. Wm. Lees Sons, Co. 300 4th St., NE Washington, DC						DATE <u>MAR 7 1969</u>			<u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR-STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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04096

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04088

1. DECEASED-NAME (Type or Print) <i>MACION</i>		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR					
				<i>E</i>		<i>BARVEY</i>		<input type="checkbox"/> Month		<input checked="" type="checkbox"/> 3		14		1969		10:30 PM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year		2d. HOUR	
<i>7</i>		<i>W</i>		<i>4/5/1905</i>		<i>63</i> YRS.		MONTHS		DAYS		<i>3</i>		<i>14</i>		<i>1969</i>		<i>11:08</i> PM			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH														Md.	
<i>Pennsylvania</i>		<i>USA</i>				<i>Montgomery</i>															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY															
<i>BETHESDA</i>		<i>Suburban Hospital</i>		<i>Home maker</i>		<i>Home</i>															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER													
<i>Pennsylvania</i>		<i>WENARCA</i>		<i>Oil City</i>		<input type="checkbox"/> YES <input type="checkbox"/> NO		<i>410 Plummer St.</i>													
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last							
<i>Frank</i>						<i>BARRETT</i>		<i>Julia</i>						<i>Connor</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
<i>NO</i>				<i>unknown</i>		<i>Cornelius BARVEY - Husband. addressee</i>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
<i>911X</i>				<i>Anoxia-</i>				<i>5 min.</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)		DUE TO, OR AS A CONSEQUENCE OF		<i>5 min.</i>													
				<i>Obstruction of larynx</i>				<i>1/2 hr.</i>													
				(c)		DUE TO, OR AS A CONSEQUENCE OF															
				<i>Aspiration of meat bolus</i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		2D. AUTOPSY?																	
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																	
		<i>10 P.M. 3 14 1969</i>		<i>Choked on large piece of meat.</i>																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State																	
		<i>Restaurant</i>		<i>3 Theiros Rest. Wisconsin Ave. Washington - D.C.</i>																	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE		John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED											
EXAMINER'S NAME (Type)		John G. Ball, M.D.								<i>March 15, 1969</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)															
<i>Removal</i>		<i>3/15/69</i>		<i>Calvary Cemetery</i>		<i>Oil City, Pennsylvania</i>															
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
<i>Joseph Gawler's Sons, Inc., Wash., D. C.</i>				<i>MAR 20 1969</i>		<i>Charles Judge</i>															

Blank lined area for handwritten notes.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 141
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04089

1. DECEASED NAME (Type or print) Marie H. Geraci		First Marie Middle H. Last Geraci		2a. DATE OF DEATH 3 Month 29 Day 69 Year		2b. HOUR 7:40 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10-12-87		6. AGE (In years last birthday) 81 YRS.	
7a. BIRTHPLACE (State or foreign country) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) McDermott		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4616 Chase Avenue		14. FATHER'S NAME First VENANZIO Middle Giovannetti Last Angelina		15. MOTHER'S MAIDEN NAME First Cuneo Middle Verona Last Bilicki		16. SOCIAL SECURITY NO. —	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. —		17. INFORMANT Verona Bilicki		17. ADDRESS 6908 Fairfax Rd. Bethesda, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CRASH 6 YRS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from OCT. , 19 63 , to 3/29 , 19 69 , that (I) (we) last saw the deceased alive on 3/29 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DR. LEO DOWRYAN				DEGREE MD.		22c. DATE SIGNED 3/29/69	
22d. PHYSICIAN'S NAME (Type) DR. LEO DOWRYAN				22e. ADDRESS BETHESDA MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-1-1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR APR 7 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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W. J. ...
Joseph ...
4-1-1900
York ...
W. J. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04098		CERTIFICATE OF DEATH						04090	
1. DECEASED-NAME (Type or print) <i>FRANCESCA J. Gilbert</i>			First Middle Last			20. DATE OF DEATH Month <i>March</i> Day <i>18</i> Year <i>1969</i>			2b. HOUR <i>12:05</i> M
3. SEX <i>FEMALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>3-19-02</i>			6. AGE (In years last birthday) <i>66</i> YRS.		IF UNDER 1 YEAR MONTHS <i>11</i> DAYS <i>21</i>
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Chevy Chase</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4611 DAVIDSON DR.</i>
14. FATHER'S NAME First <i>Joseph</i> Middle <i>Charles</i> Last <i>Filipp</i>			15. MOTHER'S MAIDEN NAME First <i>Luzina</i> Middle <i>de</i> Last <i>hezzi</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <i>214-32-9969</i>			17. INFORMANT <i>Husband</i>			Address <i>Same as Item 13.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Alcoholism</i> <i>1830</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pleural effusion of livermet effusion</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Eugene P. Librie MD</i>					DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>10 April 69</i>
22d. PHYSICIAN'S NAME (Type) <i>EUGENE P. LIBRIE</i>					22e. ADDRESS <i>10400 Conn. Ave. Kensington, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE <i>3-13-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL</i>		23d. LOCATION (City or Town) (County) (State) <i>Switland Maryland</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. Humphrey</i>					ADDRESS <i>7557-WISCONSIN AVE BETHESDA, MD.</i>		25a. REC'D BY REGISTRAR <i>MAR 14 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Maryland</i>

04082

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04099

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04091

1. DECEASED-NAME (Type or print) Robert Allan GILBERTZ			2a. DATE OF DEATH March Month 16 Day 1969 Year			2b. HOUR 1215A M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Nov. 1, 1925		6. AGE (In years last birthday) 43 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U. S. Marine Corps		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 3934 Bel Pre Road	
14. FATHER'S NAME First Unknown-deceased Middle CLARENCE E. Last GILBERTZ		15. MOTHER'S MAIDEN NAME First Unknown-deceased Middle BARBARA Last SPRINGER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes 1944-69		16b. SOCIAL SECURITY NO. 340-18-8972		17. INFORMANT Address Marine Corps/hospital records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, parotid region with widespread metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from Feb. 15 , 19 69 , to Mar. 16 , 19 69 , that (X) (we) last saw the deceased alive on Mar. 16 , 19 69 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE G. W. Taylor M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED Mar. 17, 1969					
22d. PHYSICIAN'S NAME (Type) G. W. TAYLOR, M. D.				22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-19-1969		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.			
24. FUNERAL DIRECTOR Joseph Gawler Sons ADDRESS 5130 Wisconsin Ave., N.W., Washington, D. C.				25a. REC'D BY REGISTRAR DATE MAR 20 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the funeral papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Donald W. GLADNEY						March Month 3 Day Year 69			1230 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
Male		Caucasian		Aug. 28, 1906			62 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Texas		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Naval Hospital			U. S. Navy			N/A
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Virginia			Fairfax		Fairfax		4124 Orchard Drive		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Donald W. Gladney, Sr.			Catherine Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
yes			1930-59		Mrs. Ruth Gladney, 4124 Orchard Dr. Fairfax Virginia				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary abscesses DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic carcinoma of esophagus DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from Feb. 11, 1969, to Mar. 3, 1969, that (X) (we) last saw the deceased alive on Mar. 3, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED Mar. 4, 1969	
22d. PHYSICIAN'S NAME (Type) F. H. O'CONNEL, M.D.					22e. ADDRESS Naval Hospital, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation		3-5-69		Cedar Hill Crematory		Suitland Md.			
24. FUNERAL DIRECTOR Everly Funeral Home					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Fairfax, Virginia C. M. West					DATE MAR 7 1969		<i>[Signature]</i>		

00140

MEMO TO THE DIRECTOR

RE: [Illegible]

10-10-40



10-10-40

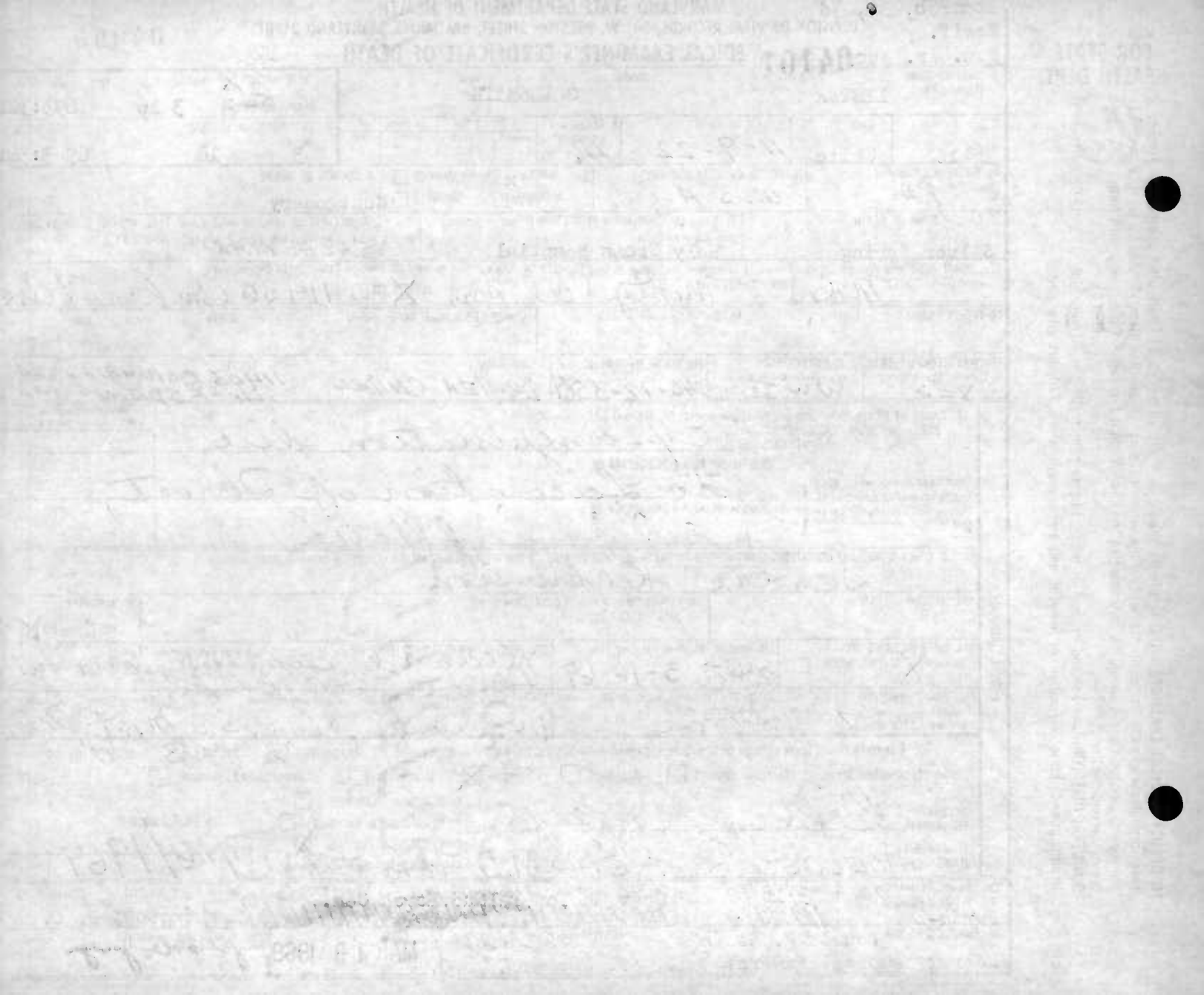


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 23b, 23c, 23d Verif. by Fun. Dir. jcp 04101		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04093	
1. DECEASED-NAME (Type or Print) LESTER				2a. DATE OF DEATH 3 16 19 69	
3. SEX Male				2c. DATE PRONOUNCED DEAD 3 16 19 69	
4. RACE White		5. DATE OF BIRTH 11-9-22		6. AGE (In years last birthday) 46 YRS.	
7a. BIRTHPLACE (State or foreign country) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESMAN	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY Montg.		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. 140-12-5581		17. INFORMANT DR. IRA CHIDEL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Eysanguination due to Laceration of Throat, self-inflicted DUE TO, OR AS A CONSEQUENCE OF (b) to Laceration of Throat, DUE TO, OR AS A CONSEQUENCE OF (c) self-inflicted		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DATE OF OPERATION		21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	
21b. TIME OF INJURY Month, Day, Year 3-16-69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) deceased, depressed, cut his throat with knife		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State 11430 Amherst Ave, S.S. Montg. Md.		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22b. DATE SIGNED 3/16/1969		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/18/69	
23c. NAME OF CEMETERY OR CREMATORY Hebrew Memorial National		23d. LOCATION (City or Town) (County) (State) Washington, D. C.		24. FUNERAL DIRECTOR Donald M. Stein	
24a. REC'D BY REGISTRAR MAR 19 1969		24b. REGISTRAR'S SIGNATURE Charles Judge		24c. ADDRESS 232 Carroll	



FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04094		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) IRINA						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 3-24		2b. HOUR 4:45		2c. DATE PRONOUNCED DEAD Month 3 Day 24 Year 1969		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 5/5/84		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		
7a. BIRTHPLACE (State or foreign country) RUSSIA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH SILVER SPRING				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Mont.		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11428 Maple View Dr.		
14. FATHER'S NAME First Efim Middle Shuranleff Last Domna						15. MOTHER'S MAIDEN NAME First Domna Middle Poliakoff Last Poliakoff						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) no				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS Katherine Golovko 11428 Maple View Dr.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED March 24, 1969				
EXAMINER'S NAME (Type) Belden R. Reap, M.D., Wheaton				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (City, Town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/27/69		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION (City or Town) Washington, D.C.		(County) (State)		
24. FUNERAL DIRECTOR ADDRESS The S. H. Hines Company Washington,						25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE William S. Under...				

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RUSSIA
 HOLY CROSS
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
04103					CERTIFICATE OF DEATH					04095									
1. DECEASED-NAME (Type or print) First Middle Last WALTER ROBERT GOVER					2a. DATE OF DEATH Month Day Year MARCH 28 1969					2b. HOUR 800P M									
3. SEX MALE			4. RACE CAUCASIAN			5. DATE OF BIRTH 5 JUN 1917			6. AGE (In years last birthday) YRS. 51			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN					
7a. BIRTHPLACE (State or foreign country) ENOSBURG FALLS, VT			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY COUNTY Md.										
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U.S. NAVY			12b. KIND OF BUSINESS OR INDUSTRY										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE VIRGINIA			13b. COUNTY ALEXANDRIA			13c. CITY OR TOWN ALEXANDRIA			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1718 OAKCREST DR							
14. FATHER'S NAME First Middle Last WALTER A GOVER					15. MOTHER'S MAIDEN NAME First Middle Last MARY HAMEL														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES			16b. SOCIAL SECURITY NO. 0080-58-638			17. INFORMANT Address KATHRYN GOVER 1718 OAKCREST DR ALEX., VA													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE ESOPHAGUS WITH WIDESPREAD METASTASIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that XX (this hospital) attended the deceased from 21 MARCH , 19 69 , to 28 MARCH , 19 69 , that XX (we) last saw the deceased alive on 28 MARCH 1969 , and that in XX (my) (our) opinion death occurred on the date and hour and from the causes stated above. XX (we) (did) (did not) view the body after death.																			
22b. SIGNATURE W. R. HIX												DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) W. R. HIX, M.D.												22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4-2-69			23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L			23d. LOCATION (City or Town) (County) (State) ARLINGTON VA.										
24. FUNERAL DIRECTOR EVERLY - WHEATLEY FUNERAL HOME ADDRESS 1500 W. BRADDOCK RD. 25a. REC'D BY REGISTRAR APR 7 1969 25b. REGISTRAR'S SIGNATURE Charles Judge																			

04100

U.S. DEPARTMENT OF THE ARMY

ARMY MEDICAL DEPARTMENT

CHIEF OF MEDICAL SERVICE

UNIT

U.S.

U.S. ARMY MEDICAL DEPARTMENT

DATE OF BIRTH

ARMED

U.S. ARMY MEDICAL DEPARTMENT

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U.S. ARMY MEDICAL DEPARTMENT

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04096

04104

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Marie G. Grady			2a. DATE OF DEATH Month 3 Day 6 Year 69			2b. HOUR 10:38 AM			
3. SEX F		4. RACE W		5. DATE OF BIRTH 2/18/1908		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10225 Kensington Hwy	
14. FATHER'S NAME First Edward F. Middle Gallagher Last Gallagher				15. MOTHER'S MAIDEN NAME First Mame Middle Full Last Full					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 220-44-53541		17. INFORMANT Neice Mrs. Beall Hollabaugh 15244 Hardwood Lane McLean, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: 4123 IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (c) 10 years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2/1/69 , to 3/6/69 , that (I) (we) last saw the deceased alive on 3/6/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John J. Curry				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/6/69	
22d. PHYSICIAN'S NAME (Type) JOHN J. CURRY				22e. ADDRESS 9811 Georgia Ave Silver Spring					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-10-69		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Maryland			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				ADDRESS		25a. REC'D BY: REGISTRAR MARK 12 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

For the year ending 1910

Y. P. 1910

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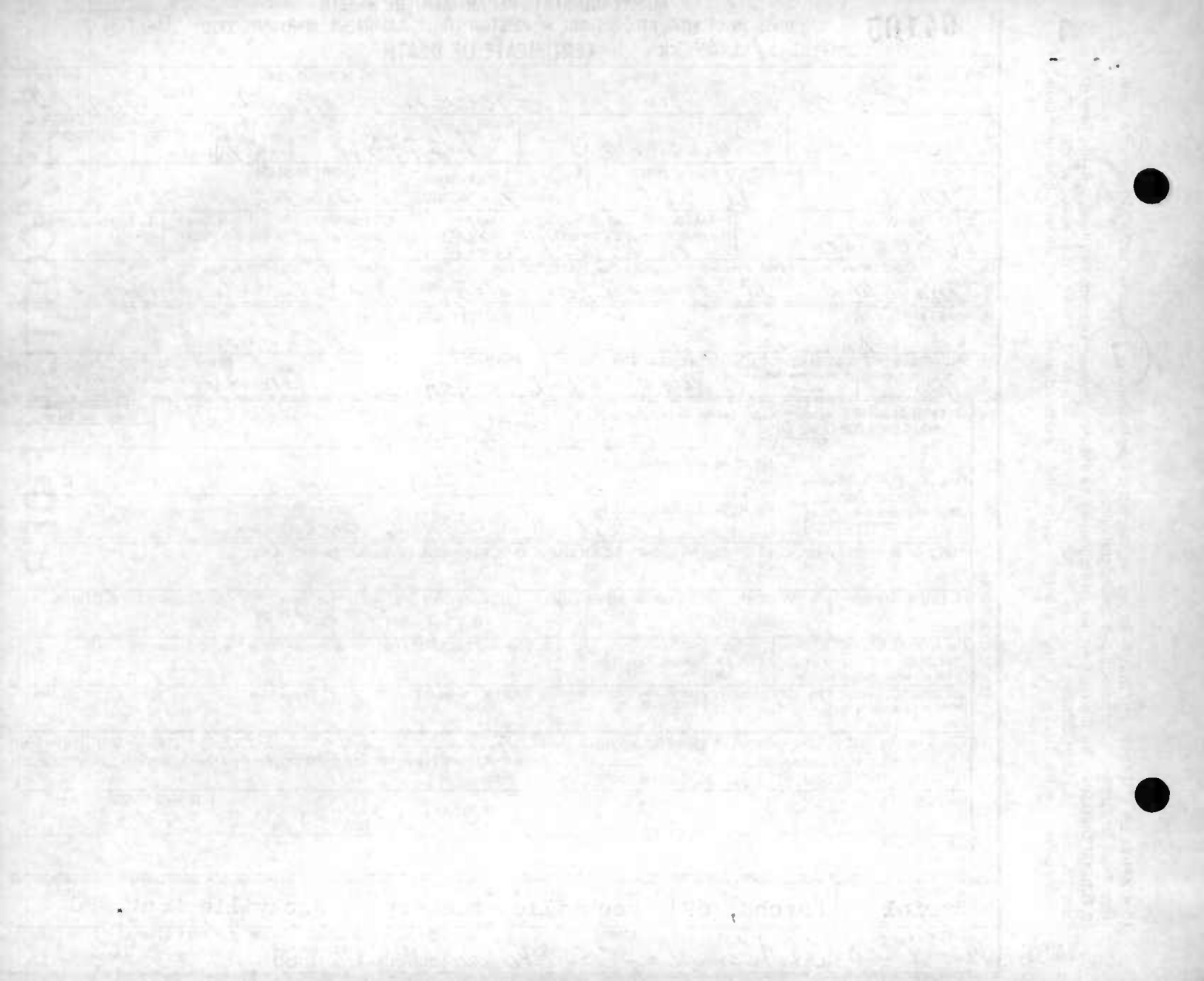
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04105		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04097	
Items 5&6 Film G411 4/11/69 kk					
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) First Middle Last		2a. DATE OF DEATH Month Day Year		2b. HOUR	
Edith H. Green.		March- 3 1969		12 noon	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		Caucasian		1884 7/27/817	
6. AGE (In years last birthday)		8. MARRIED		9. COUNTY OF DEATH	
81 YRS.		NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery Md.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	
Minn.		U.S.A.		Kendall Hills Nursing Home	
10. CITY OR TOWN OF DEATH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Wheaton					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. STREET AND NUMBER	
Maryland		Montgomery		3920-Washington St.	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
UNKNOWN		Hildegard UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		214 01 2575 D		Winship I GREEN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4339		24 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b)		Cerebral Infarction		36 hrs	
DUE TO, OR AS A CONSEQUENCE OF (c)		Cerebral Thrombosis			
Cerebral Arteriosclerosis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 6/1/1965, to 3/5/1969, that (I) (we) last saw the deceased alive on 3/4/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. DATE SIGNED			
Robert A. Humphrey		3/5/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a. BURIAL, CREMATION, ETC. (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		March 8, 69		Rockville cemetery	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Humphrey		MAR 12 1969		J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04106		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04098			
1. DECEASED-NAME (Type or print) First Middle Last						2a. DATE OF DEATH Month Day Year		2b. HOUR	
HARRY GREENBERG						Mar Month 23 Day		Year 69 6:45 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		2-14-99		70 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Russia		USA				MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		Holy Cross		CAB DRIVER		TAXI			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		P. G.		HATTS.				1005 CHILLUM ROAD	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last							
UNKNOWN		UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes, no, or unknown		578-24-3424		Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION									
4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) SEVERE CORONARY ARTERIOSCLEROSIS									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1965 to 3/23, 1969, that (I) (we) last saw the deceased alive on Mar 23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert Kramer					22c. DATE SIGNED		Mar 23, 1969		
22d. PHYSICIAN'S NAME (Type) ROBERTO KRAMER					22e. ADDRESS		8484-16th St. N. DC		
23a. BURIAL, CREMATION, or other (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/25/69		NATH. MEM. PARK		FALLS CHURCH VA.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Beebe Funeral Home 4217 9th St					MAR 26 1969		Charles Judge		

04102

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04107					04099					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last Joseph William Gregory, Jr.					Month 3 Day 20 Year 69			2:55 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		10-28-04		64 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Montgomery County Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hosp.			Manager		Paint & Hard.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Montgomery		Sil. Spr.				9802 Forest Grove Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last Joseph William Gregory			First Middle Last Carrie Mae Springmann							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			214-03-8086		Elizabeth D. Gregory 9802 Forest Grove Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis & Myocardial Infarction</u> QUESTIONS OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>18 March 1969</u> , to <u>20 March 1969</u> , that (I) (we) lost saw the deceased alive on <u>18 March 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>William D. And, M.D.</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3/20/69</u>			
22d. PHYSICIAN'S NAME (Type) William D. And, M.D.					22e. ADDRESS 9006 Colesville Road, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3/24/69		Fort Lincoln Cemetery		Bladensburg, Maryland				
24. FUNERAL DIRECTOR		24a. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Glen Carter		8434 Georgia Avenue		MAR 28 1969		Warner E. Pumphrey, Inc. Silver Spring, Maryland				

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1. *Staphylococcus aureus* (100%)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>04108</div> <div>Item 23 Film 411 4/2/69 kk</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>04100</div>									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
BABY			BOY			GROOMS			3 Month 23 Day 69 Year 7:35AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
MALE		NEGRO		3-23-69		YRS.		1 31	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
OLNEY		MONTGOMERY GENERAL HOSP.		NEWBORN					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		MONTGOMERY		GAITHERSBG.				17930 LAYTONSVILLE ROAD	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JAMES LELAND WILCOX			DENISE DARCEL GROOMS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO				MEDICAL RECORDS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>PREMATURITY</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <u>3-23</u> , 19 <u>69</u> , to <u>3-23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-23-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<i>Chester Lee Roy Wagstaff</i>		3-24-69							
22b. PHYSICIAN'S NAME (Type)		22c. ADDRESS							
CHESTER LEEROY WAGSTAFF, M.D.		MEDICAL CENTER, SANDY SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Removal		3/23/69		Hunter Laboratory					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						MAR 26 1969		<i>[Signature]</i>	

05100

UNITED STATES GOVERNMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT 5
30M. REV. 1-68

04109		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04101	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <u>ROTH</u>		First <u>C.</u> Middle <u>E.</u> Last <u>Gude</u>		2a. DATE OF DEATH <u>3</u> Month <u>5</u> Day <u>69</u> Year		2b. HOUR <u>7A</u> M	
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <u>11-29-99</u>		6. AGE (In years last birthday) <u>69</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>U.A.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery County</u> Md.	
10. CITY OR TOWN OF DEATH <u>Silver Spring Md</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Wheaton</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>4011 Randolph Road</u>		14. FATHER'S NAME First <u>Preston</u> Middle <u></u> Last <u></u>		15. MOTHER'S MAIDEN NAME First <u>Josephine</u> Middle <u>Potts</u> Last <u></u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u>		16b. SOCIAL SECURITY NO. <u>220-44-4643</u>		17. INFORMANT <u>Hospital Record - Silver Spring, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Klebsiella Aerobacter Septicemia</u> <u>2509</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Secretory Diarrhea</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 wks</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1) Diabetes Mellitus: Generalized arteriosclerosis - Old CVA's - Left Hemiplegia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>68</u> , to <u>March 5</u> , 19 <u>69</u> , that (I) <u>did</u> was lost saw the deceased alive on <u>Feb 4</u> , 19 <u>69</u> , and that in (my) <u>final</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>viewed</u> did not view the body after death.		22b. SIGNATURE <u>Michael Dobridge</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>March 5, 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>Michael Dobridge</u>		22e. ADDRESS <u>9801 Georgia ave N W</u>		22f. ADDRESS <u>Silver Springs Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>March 8, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 10 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

04103

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MAR 10 1961

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04110

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04102

1. DECEASED-NAME (Type or Print) JAMES A HAMILTON			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 3-18 19 69			2b. HOUR 6:35 P.M.	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 8/1/02	6. AGE (in years last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 3 Day 18 Year 19 69	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 420 University Blvd.W.							
14. FATHER'S NAME Oliver W. Hamilton			15. MOTHER'S MAIDEN NAME Edith Sandy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 579-05-9044		17. INFORMANT Doris Gray ADDRESS Item # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction with thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral arteriosclerosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic heart disease							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/19/1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/22/69		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike				25a. REC'D BY REGISTRAR DATE MAR 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04111									
04103									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Raymond			Mahlon			March 31 69		1:45 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		March 6, 1903		66 YRS.		0 25	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Arkansas		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Naval Hospital				Marine Corps (Ret)		Bandsman	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
D. C.		V		Washington				2025 Eye St., N.W.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Unknown			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/>		WWII - 577 42 3784		Washington		D.C.			
Yes		WWII - 577 42 3784		Mrs. Mary Hamilton, 2025 Eye St., N.W.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardiomyopathy with multiple old infarcts									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
Carcinoma of the lung with metastases									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from Mar. 30, 1969, to Mar. 31, 1969, that (X) (we) last saw the deceased alive on Mar. 31, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
T.M. Schenk		2APRIL69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
T. M. SCHENK		Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		APRIL 4/69		Arlington National Cem		Arlington Va.			
24. FUNERAL DIRECTOR		Hysong Funeral Home		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
1300 N Street, N.W. Washington, D. C.				Charles M. Hysong		DATE APR 7 1969		Charles Judson	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04112		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04104	
Items#23a,b,c,d 22b Film G411 4/3/69					
1. DECEASED-NAME (Type or print) B_a by Boy Hansen			2a. DATE OF DEATH Month Day Year March 25 1969		2b. HOUR P 9:40 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH 3/25/69		6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN 36
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2705 Briggs Road
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last Kathleen Louise Hansen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT records Address Montgomery General Hospital, Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>immaturity</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>premature labor</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Chester Leroy Wagstaff				22c. DATE SIGNED 3-26-69	
22d. PHYSICIAN'S NAME (Type) Chester L. R. Wagstaff, M.D.				22e. ADDRESS Sandy Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-26-69		23c. NAME OF CEMETERY OR CREMATORY Hunter Laboratory	
24. FUNERAL DIRECTOR		ADDRESS		23d. LOCATION (City or Town) (County) (State) 915 19th St. n.w. Wash. D.C.	
25a. REC'D BY REGISTRAR MAR 27 1969				25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04113

04105

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) RENA LUCILLE HARAB			2a. DATE OF DEATH Month 3 Day 22 Year 69			2b. HOUR 1:50 PM						
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 5-30-19		6. AGE (In years last birthday) 49 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0		
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			Md.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GROSVENOR LANE NURSING & CONVALESCENT CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERK		12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY Montgomery		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 13203 BLAXFIELD CT.			
14. FATHER'S NAME First Middle Last JOSEPH I. POSNER			15. MOTHER'S MAIDEN NAME First Middle Last MIRIAM HARRISON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 133-01-4603		17. INFORMANT DAUGHTER MISS RHONA B. HARAB Address 12203-BLAXFIELD CT ROCKVILLE MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma 174X DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Breast DUE TO, OR AS A CONSEQUENCE OF (c) 3 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mos		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5-9-68 , 1968, to 3/22 , 1969, that (I) (we) last saw the deceased alive on 3/20 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE G. Lennard Gold MD					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/22/68					
22d. PHYSICIAN'S NAME (Type) G. LENNARD GOLD MD					22e. ADDRESS 9801-GEORGIA AVE SILVER SPG. MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) MAR. 25, 1969		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL CEM.			23d. LOCATION (City or Town) (County) (State) ARLINGTON V.A.					
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS					ADDRESS 3501-14th St. N.W. WASH. D.C.		25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE John Charles Judge			

MEDICAL CERTIFICATION

04113

OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS

UNITED STATES DEPARTMENT OF COMMERCE
WASHINGTON, D. C. 20540

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04114 CERTIFICATE OF DEATH 04106											
1. DECEASED-NAME (Type or print) First Rebecca Middle G Last Harvill				2a. DATE OF DEATH March Month 13 Day 1969 Year				2b. HOUR 1:30 P M			
3. SEX female		4. RACE white		5. DATE OF BIRTH April 12, 1907		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Penna		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 12325 New Hampshire Avenue Colonial Villa				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Beautician		12b. KIND OF BUSINESS OR INDUSTRY Beauty Parl.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Sp.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 131 Fleetwood Terrace			
14. FATHER'S NAME First Ernest Middle A. Last Hixson				15. MOTHER'S MAIDEN NAME First Jennie Middle Hanks Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				16b. SOCIAL SECURITY NO. yes		17. INFORMANT Nursing Home Records-12325 New Hampshire Av. Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lower lobe pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized rheumatoid arthritis - severe											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Dec 1958, to Mar 13, 1969, that (I) (we) last saw the deceased alive on Mar 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harry N. Carlton, MD				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED Mar 13, 1969			
22d. PHYSICIAN'S NAME (Type) HARRY N. CARLTON				22e. ADDRESS 8811 Cokesville Rd, Silver Spring, Md.							
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> (Specify)		23b. DATE Mar 16, 1969		23c. NAME OF CEMETERY OR CREMATORY Everett Cemetery		23d. LOCATION (City or Town) Everett		(County) Pennsylvania		(State)	
24. FUNERAL DIRECTOR Barner E. Pumphrey, Inc. 8434 Gd. Ave. Sit. Spg. Md. C. Glen Carter				25a. REC'D BY REGISTRAR DATE MAR 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

DATE

Reference

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April 12, 1907

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
04115										04107	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First		Middle		Last			2a. DATE KNOWN OF DEATH	
Joseph M. Hausler										ESTIMATED <input checked="" type="checkbox"/> 3 28 1969	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
M.		W.		Jan 15, 1880		89 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Michigan			U.S.A.						Montgomery Md.		
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda				Westwood Home River Rd.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
D.C.				13b. COUNTY Washington		A.W.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4600 Connecticut Ave. N.W.	
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
NO				598-46-6537		MR. EUGENE GALLAGHER, NEPHEW			FALLS CHURCH, VA		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Asphyxia</u>										5 min.	
953 X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Hanging</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				12:00 AM 3-28 1969				Hung self with rope on recondon			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Nursing Home				5101 Richfield Rd. Bethesda Montgomery Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
John G. Ball								March 28, 1969			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
John G. Ball											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			4-1-1969		Gate of Heaven Cemetery			Silver Spring, Montgomery Co., Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016						DATE APR 7 1969		J. Charles Judge			

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

APR 5 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151 (1)
30M REV. 11-68

04116

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
BLANCHE			NUNN	HAZZARD	March 12, 1969			6:00 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		July 3, 1891		77 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		U.S.A.				Montgomery Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Kensington		Carroll Hall Nur. Home		Homemaker		****					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Montg.		Bethesda				7604 Westfield Drive,		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Mercer			C.	Nunn		Mollie					Dabney
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			7604 Westfield Dr. Address			
No			578-10-5881		L-D. Mrs. Helen Ake, Bethesda, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>										Sudden	
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Arteriosclerotic Cardiovascular Disease</u>										10 yrs	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Diabetes mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
		P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 16, 1967</u> , to <u>March 12, 1969</u> , that (I) <u>did</u> saw the deceased alive on <u>March 3, 1969</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>do</u> (did) <u>not</u> view the body after death.											
22b. SIGNATURE		STEPHEN W. DEJTER, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
								3-12-1969			
22d. PHYSICIAN'S NAME (Type)		STEPHEN W. DEJTER, M.D.		22e. ADDRESS		6719 WILSON LANE, BETHESDA, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		4-14-69		Parklawn Cemetery		Rockville, Montg.		Maryland			
24. FUNERAL DIRECTOR		ROBERT A. PUMPHREY,		755 Wisconsin Ave. Bethesda, Md.		REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						DATE		MAR 19 1969			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04117

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04109

1. DECEASED-NAME (Type or print) BRUCE First Middle Last			2a. DATE OF DEATH Month 3 Day 1 Year 69			2b. HOUR 8:25 P.M.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 8-12-1882		6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH TAKOMA PARK			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN. & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY PRINCE GEORGES			13c. CITY OR TOWN ADELPHI			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First BENJAMIN Middle Last HEATER			15. MOTHER'S MAIDEN NAME First ELIZABETH Middle Last CARPER			13e. STREET AND NUMBER 1814 METZEROTT Rd.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. -			17. INFORMANT Hospital Records & F.D. Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4124 IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. Na. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 2-19 , 19 67 , to 3-1 , 19 67 , that (I) (we) lost saw the deceased alive on 3-1 , 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Morton Aitschuler M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 3-1-69				
22d. PHYSICIAN'S NAME (Type) Morton Aitschuler, M.D.						22e. ADDRESS 9205 New Hampshire Ave. Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) removal			23b. DATE 3/2/69		23c. NAME OF CEMETERY OR CREMATORY Springhill,			23d. LOCATION (City or Town) (County) (State) Charleston, W.Va.		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, 5130 Wisconsin Av., NW, Washington, D.C.						25a. REC'D BY REGISTRAR MAR 6 1969 DATE		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

04117

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of birth		6. Date of birth		7. Cause of death		8. Place of death	
9. Signature of physician		10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of burial place		18. Signature of burial place		19. Signature of burial place		20. Signature of burial place	
21. Signature of burial place		22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place		28. Signature of burial place	
29. Signature of burial place		30. Signature of burial place		31. Signature of burial place		32. Signature of burial place	
33. Signature of burial place		34. Signature of burial place		35. Signature of burial place		36. Signature of burial place	
37. Signature of burial place		38. Signature of burial place		39. Signature of burial place		40. Signature of burial place	
41. Signature of burial place		42. Signature of burial place		43. Signature of burial place		44. Signature of burial place	
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49. Signature of burial place		50. Signature of burial place		51. Signature of burial place		52. Signature of burial place	
53. Signature of burial place		54. Signature of burial place		55. Signature of burial place		56. Signature of burial place	
57. Signature of burial place		58. Signature of burial place		59. Signature of burial place		60. Signature of burial place	
61. Signature of burial place		62. Signature of burial place		63. Signature of burial place		64. Signature of burial place	
65. Signature of burial place		66. Signature of burial place		67. Signature of burial place		68. Signature of burial place	
69. Signature of burial place		70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
73. Signature of burial place		74. Signature of burial place		75. Signature of burial place		76. Signature of burial place	
77. Signature of burial place		78. Signature of burial place		79. Signature of burial place		80. Signature of burial place	
81. Signature of burial place		82. Signature of burial place		83. Signature of burial place		84. Signature of burial place	
85. Signature of burial place		86. Signature of burial place		87. Signature of burial place		88. Signature of burial place	
89. Signature of burial place		90. Signature of burial place		91. Signature of burial place		92. Signature of burial place	
93. Signature of burial place		94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place		100. Signature of burial place	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>04118</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>04110</div>											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Russell Statham			Henry			Month Day Year			1969 10 52		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	W	March 25	43	MONTHS	DAYS	HOURS	MIN.	Month Day Year	1969 10 52		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
No. Carolina		U.S.A.				Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban			Match Maker					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Mont		Bethesda		YES <input type="checkbox"/> NO <input type="checkbox"/>		1217 Cardell Cove		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Russell Statham			Henry Sr.			Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
No.			246-34-3299			Address Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction										3 days	
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion.										3 days	
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis - Severe -										years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)		John G. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		March 8, 1969			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		3/11/69		Academy Cemetery		Asheville, N. C.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tyson Wheeler F. H. 1331 Rockville Pike Rockville, Maryland						DATE MAR 12 1969		[Signature]			

RT-20

04118

10-1-40

John A. Bell

University of

University of

University of

University of

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University of

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 411 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
4-24-69 ans DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04119

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04111

1. DECEASED-NAME (Type or Print)			First Middle Lost			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 3-22-1969			2b. HOUR 4:36 PM		
ROBERT LEON HERNDON											
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR		
Male	White	7-14-19	49 YRS.			3-22-1969			4:36 PM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
D.C.		USA				Montgomery			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Wash. San. & Hosp.			Sign Painter			Dept. of Int		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Md.			P.G.			Adelphi			7975 18th Ave.		
14. FATHER'S NAME First Middle Lost				15. MOTHER'S MAIDEN NAME First Middle Lost							
Budd Herndon				Grace Horton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
yes			WW 2			Mrs. Mildred Herndon - Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure,</u> <u>7824</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Etiology undetermined</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE		22b. DATE SIGNED									
EXAMINER'S NAME (Type)		3/22/1969									
Belden R. Reap, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		MAR 25, 1969		Gate of Heaven		Wheaton		MD			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. H. Aitman 4748 W. Ave. NW								MAR 26 1969		J. Charles Judge	

6530

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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156350

1991 - 1992

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 411
4-7-69 ans DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04120

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04112

1. DECEASED-NAME (Type or Print)		First ELLEN		Middle ELIZABETH		Last HINDMAN		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year 3- 25- 1969		2b. HOUR 2:43 PM			
3. SEX F	4. RACE W	5. DATE OF BIRTH 10-10-14	6. AGE (In years last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year 3- 25 1969		2d. HOUR 2:43 PM			
7a. BIRTHPLACE (State or foreign country) DC		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery							
10. CITY OR TOWN OF DEATH Takoma Park, Md.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk				12b. KIND OF BUSINESS OR INDUSTRY Private	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Pri. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6226 20th Place			
14. FATHER'S NAME First Middle Last Arthur Deceased J. Bugden				15. MOTHER'S MAIDEN NAME First Middle Last Marguerite Werten Bugden Baker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 578-10-2608		17. INFORMANT (Husband) Mother		ADDRESS Wm. J. Hindman-6226-20th Pl., Hyattsville					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty metamorphosis of liver, severe 5718 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Belden R. Reap				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 3/25/1969					
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (City or town or county) Wheaton					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 29, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City or town) (County) (State) Sniteland Maryland					
24. FUNERAL DIRECTOR Glen Carter Warner E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR APR 1 1969				25b. REGISTRAR'S SIGNATURE Charles Judge					

Form with multiple sections and fields, including a header area with "MEDICAL" and "HISTORICAL" labels, and a large section with "X" marks. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise. The text is mostly illegible due to the rotation and low contrast.

Header area (rotated 90 degrees clockwise):

- MEDICAL
- HISTORICAL

Main body (rotated 90 degrees clockwise):

- Section 1: [Illegible text]
- Section 2: [Illegible text]
- Section 3: [Illegible text]
- Section 4: [Illegible text]
- Section 5: [Illegible text]
- Section 6: [Illegible text]
- Section 7: [Illegible text]
- Section 8: [Illegible text]
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- Section 10: [Illegible text]
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- Section 100: [Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04121 CERTIFICATE OF DEATH 04113											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
SARAH		F.		HINES				Mar. 26, 1969		2:45 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Cauc.		Nov. 21, 1885		83 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Illinois		U. S.				Montgomery				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Carriage Hill Nursing Home		Retired							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Montgomery		Silver Spring				2100 Belvedere Blvd.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Frank M. Lloyd								Alice Lenore Nichols			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		D		Address		Same as Item 13.	
No		299-01-6141		Alice L. Hines							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>long standing pulmonary emboli</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>2-4, 1964</u> , to <u>3-26, 1969</u> , that (I) (we) last saw the deceased alive on <u>3-25, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Jason Berger, M.D.		800 PERKINS DRIVE SILVER SPRING, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		3-29-69		Rock Creek Cemetery		Washington, D. C.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
ROBERT A. PUMPHREY, Bethesda, Maryland				APR 1 1969		Charles Judge					

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8-15 Am 3/4/69 Case Cleared By Dr. Belden
Reap, coroner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04122

CERTIFICATE OF DEATH

04114

1. DECEASED-NAME (Type or print) HERBERT			First	Middle	Last	2a. DATE OF DEATH Month 3 Day 4 Year 1969			2b. HOUR 4:55 a 5 m		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11/11/23			6. AGE (In years lost birthday) 45 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY STATE DEPT.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Mont.		13c. CITY OR TOWN Sil.Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 814 Daleview Drive		
14. FATHER'S NAME Herbert J. Hodge			First	Middle	Last	15. MOTHER'S MAIDEN NAME Mary L. Fergerson			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Mary Ann Hodge Silver Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction, left 4109 DUE TO, OR AS A CONSEQUENCE OF postero-septal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 7 YEARS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) OBESITY, ENDOGENOUS											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8/10 , 19 57 , to 3/4 , 19 69 , that (I) (we) lost saw the deceased alive on 3/4 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James A. Roberts M.D.						22c. DATE SIGNED MARCH 4, 1969					
22d. PHYSICIAN'S NAME (Type) James A. Roberts, M.D.						22e. ADDRESS 8907 Georgia Ave., Sil.Spr., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Mar 6, 1969			23c. NAME OF CEMETERY OR CREMATORY Rock Creek			23d. LOCATION (City or Town) (County) (State) Washington, D.C.		
24. FUNERAL DIRECTOR Warner E. Humphrey Inc.						25a. REC'D BY REGISTRAR MAK 7 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04123		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04115		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 20 M	
MARTIN				Hofmann	MAR 15 1969		20	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		JUL 11 1912		56 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Germany	U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life. If retired, state occupation)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring		Holy Cross Hosp		RATE Clerk Southern Railway				
13a. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
District of Columbia		Washington				1500 MASS AVE NW		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last	
LOUIS				HOFMANN	KINA		THALHEIMER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
YES		WW II		ERHST HOFMANN		10113 HEREFORD PL. SIL. SPE. MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) 4109 Cardiac arrest								
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction, primary								
DUE TO, OR AS A CONSEQUENCE OF (c) 10 days								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 3-5, 1964, to 3-15, 1969, that (I) (we) last saw the deceased alive on 3-15, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22c. DATE SIGNED				
MORRIS PERRY, M.D.		11602 GEORGIA AVE. SIL. SPE. MD.		3-15-69				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		3/16/69		BYAL ISRAEL CEM.		DIXON HILL MD.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
GOLDBERG FUNERAL HOME		ST. N.W.		MAR 18 1969		Charles Judge		

Handwritten text, likely a letter or report, containing several lines of cursive script. The text is mostly illegible due to fading and bleed-through from the reverse side. Some discernible words include "Hofmann", "July 11, 1913", and "District".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04124									
04116									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Fred			W			Month 3 Day 31 Year 69		11:10 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		W		2-20-1891		78 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Iowa						Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		H. C. H.		Supt. Engr. Research					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Fla.		V		W. Palm Beach				348 Potter Road.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Charles L. Holzberger			Katherine D. Piper						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address	
No			577-09-9282A			Fred W. Holzberger Jr.		4203-74th Hy., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>								1 1/2 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (b)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>3/23</u> , 19 <u>69</u> , to <u>3/31</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/31</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
<u>G. Leonard Gray</u>									4/1/69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/3/69		Mt. Olivet Cem.		Wash., D.C.			
24. FUNERAL DIRECTOR					24a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Nalley's Funeral Home Inc.					APR 7 1969		<u>Charles Judge</u>		

James H. Holmberg, Retired, U.S. Army

67-08-0884, Fred W. Holmberg, Jr., U.S. Army

(2)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04125										
CERTIFICATE OF DEATH										
04117										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
MARtha Belle			Howell			March 21 1969		1A ¹⁰ M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
FEMALE		Caw.		9/5/1884		87 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Kentucky		U.S.A.				Montgomery		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Drosvenor Lane Nursing Home							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10224 Hatherleigh Dr.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Hugh Warren			SUSAN Bell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No			319-28-63310		Mrs. Wendall Richards		Bethesda, Md. 10224 Hatherleigh Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) 2041									4 weeks	
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic lymphocytic leukemia									12 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Arteriosclerotic Heart Disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from June 15, 1963, to March 21, 1969, that (I) (we) last saw the deceased alive on March 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Stanley M. Bialek									21 March 69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
STANLEY M. BIALEK, M.D.					8218 Wisconsin Ave. Beth. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3-24-69		Toulon Cemetery		Toulon, Stark Co. Ill.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey					7557 Wisconsin Ave		MAR 26 1969			

04152

REPUBLIC OF DENMARK

MINISTRY OF THE INTERIOR

04152

Handwritten text, mostly illegible due to bleed-through from the reverse side of the page. The text appears to be a formal document or report, possibly related to the Ministry of the Interior of Denmark.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04126										
CERTIFICATE OF DEATH										
04118										
1. DECEASED NAME (Type or print) John Thorman Hudman					2a. DATE OF DEATH Month March Day 28 Year 1969			2b. HOUR A 11:10 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5 July 1925		6. AGE (In years last birthday) 43 YRS.		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Statistician			12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince Georges		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3204 Ryan Drive	
14. FATHER'S NAME First John Middle P. Last Hudman			15. MOTHER'S MAIDEN NAME First Sarah Middle Thorne Last Thorne							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO. 461-22-9335		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive Visceral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Subdural Hematoma, Bilateral DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Myelogenous Leukemia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days 6 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from 13 February, 1969, to 28 March, 1969, that (X) (we) last saw the deceased alive on 28 March 1969, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Sherrard L. Hayes M.D.					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 28 March 1969	
22d. PHYSICIAN'S NAME (Type) Sherrard L. Hayes, M.D.					22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-31-1969		23c. NAME OF CEMETERY OR CREMATORY Kenedy Cemetery			23d. LOCATION (City or Town) Kenedy		(County) (State) Texas	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland					25a. REC'D BY REGISTRAR DATE APR 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

05140

04127

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Sarah E. Hughes</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>6</i> Year <i>1969</i>			2b. HOUR <i>10 P.</i>									
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2/18/84</i>		6. AGE (In years last birthday) <i>85</i> YRS.		7. UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		8. IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>					
7a. BIRTHPLACE (State or foreign) <i>MASSACHUSETTES</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>						
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Secretary</i>			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Chesapeake</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>5600 Warwick Pl.</i>			
14. FATHER'S NAME First <i>Owen</i> Middle <i></i> Last <i></i>			15. MOTHER'S MAIDEN NAME First <i>Sarah Elizabeth</i> Middle <i>Davis</i> Last <i></i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>135-32-0133</i>			17. INFORMANT <i>Mary E. at Sepulchre above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma, colon with metastasis</i> <i>1538</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>April</i> Day <i>6</i> Year <i>1969</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. <i>3/5</i> City or Town <i>Bethesda</i> County <i>Montgomery</i> State <i>MD.</i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 19 <i>68</i> , to <i>3/6</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>3/5</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>J. Blaine Fitzgerald MD</i>				22c. DATE SIGNED <i>3/6/69</i>				22d. PHYSICIAN'S NAME (Type) <i>J. BLAINE FITZGERALD, M. D.</i>				22e. ADDRESS <i>8218 WISC. AVE. BETHESDA, MARYLAND.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE <i>3-11-69</i>				23c. NAME OF CEMETERY OR CREMATORY <i>MT. ST. MARY'S CEMETERY</i>				23d. LOCATION (City or Town) (County) (State) <i>PAWTUCKET R. I.</i>			
24. FUNERAL DIRECTOR <i>FRANCIS J. COLLINS</i>				ADDRESS <i>500 UNIVERSITY BLVD. WEST, SILVER SPRING, MD.</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

75130

THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15
45M - 1 69

04128		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04120	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Pearl</i>		First <i>E</i>		Middle <i>Hyman</i>		Last	
3. SEX <i>Female</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>10/9/81</i>		6. AGE (In years last birthday) <i>87</i>	
7a. BIRTHPLACE (State or foreign country) <i>Richmond, Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <i>Joseph Ellington</i>		15. MOTHER'S MAIDEN NAME <i>Martha Flourney</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <i>212-52-1579T</i>		17. INFORMANT <i>Francis C. Hyman-222 Blandford St.,</i>				Address <i>Rockville, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <i>4339</i> IMMEDIATE Cause (a) <i>Cerebral Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>2-25</i> , 19 <i>69</i> , to <i>3-17</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3-16</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>James W. Egan Md</i>		22c. DATE SIGNED <i>3-17-69</i>		22d. PHYSICIAN'S NAME (Type) <i>James W. Egan</i>			
22e. ADDRESS <i>5413 Cedar Lane - 206C Bethesda</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/19/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>George Washington Memorial Prince George Co., Md.</i>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Ryson Wheeler Funeral Home-1331 Rockville Pike</i>		ADDRESS <i>Rockville, Md.</i>		25. REC'D BY REGISTRAR <i>MAR 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Francis Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115
45M - 1

04130		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04121	
1. DECEASED-NAME (Type or print) <i>Edward B. Irwin</i>		2a. DATE OF DEATH Month <i>3</i> Day <i>15</i> Year <i>69</i>		2b. HOUR <i>5:55</i> M	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>9-27-19</i>	6. AGE (In years last birthday) <i>49</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Victor, Iowa</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Driving Instructor</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Sp.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>12317 Charles Rd.</i>	
14. FATHER'S NAME First <i>Edwin</i> Middle <i>Irwin</i> Last <i>Irwin</i>		15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>yes WW 11</i>	16b. SOCIAL SECURITY NO. <i>478-05-1851</i>	17. INFORMANT <i>Judith A. Irwin- Item # 13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiovascular collapse</i> <i>571.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>hepato failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>carcinosis of liver</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>renal shutdown</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>March 11, 1969</i> , to <i>March 13, 1969</i> , that (I) (we) last saw the deceased alive on <i>March 13, 1969</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W R Ehrmantrant MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <i>W R Ehrmantrant</i>		22e. ADDRESS <i>1125 Rockville Pike</i>		22c. DATE SIGNED <i>3/18/69</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>3/20/69</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md. 20852</i>		
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home-1331 Rockville Pike</i>		ADDRESS <i>Rockville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 21 1969</i>	25b. REGISTRAR'S SIGNATURE <i>W. J. Judge</i>

06130

Victor, Iowa, USA

Defining Institution

Edwin Lewis

(in person)

Yes 11 068-02-1821 Judith A. Lewis - Area 3 12

Serial 370792 Baltimore National
Area Specialist (unrec'd) - 1931
Rockville, Md.

Baltimore, Md.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04129

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04122

1. DECEASED-NAME (Type or Print) <i>Howard</i> First Middle Last <i>Wilkinson Jackson</i>		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year <i>March 16 1969</i>		2b. HOUR 50 P.M.
3. SEX <i>Male</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>3/23/26</i>	6. AGE (In years last birthday) <i>42</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U-S-A</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Mass Collector</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Blue, Mexican</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>	13b. COUNTY <i>Mont</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>10910 Seven Lock Rd</i>
14. FATHER'S NAME First Middle Last <i>John Wesley Jackson</i>	15. MOTHER'S MAIDEN NAME First Middle Last <i>May Times</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Same as above</i> <i>Matthew - Mary Jackson</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive hemorrhage, lung and mediastinum</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Knife wound of neck (left side)</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 1/2 hr.</i> <i>15 1/2 hr.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. TIME OF INJURY Month, Day, Year HOUR AM. <i>11 P.M. 3/15 1969</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Struck on neck during fight with wife</i>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>	21f. LOCATION Street or R.F.D. No. City or Town County State <i>703 Lenmore Ave Rockville Montgomery Md</i>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John B. Bell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>March 16 1969</i>
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>3-21-69</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Park Cem.</i>	23d. LOCATION (City or Town) (County) (State) <i>Rockville Montg Md.</i>	
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>		ADDRESS <i>Rockville Md.</i>	25a. REC'D BY REGISTRAR DATE <i>MAR 26 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. [illegible]</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
30M REV. 1-69

04131		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04125					
1. DECEASED-NAME (Type or print)		First Alberta		Middle P.		Last Johnson		2a. DATE OF DEATH 3 Month 21 Day 69Year		2b. HOUR 2:55pm	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH Sept. 15, 1877		6. AGE (In years last birthday) 91 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Brinklow		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Brinklow		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 18635 Brooke Road			
14. FATHER'S NAME First Isaac		Middle Smith		Last Smith		15. MOTHER'S MAIDEN NAME First Minnie		Middle ?		Last ?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Hallie Williams: Sligo Mill Rd Takoma Park, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL DISEASE</u> 4109 DUE TO, OR AS A CONSEQUENCE OF <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> (c) <u>YES</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>YES</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>CONGESTIVE HEART FAILURE: CHRONIC RENAL DISEASE</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1, 1963</u> , to <u>3/21, 1969</u> , that (I) (we) last saw the deceased alive on <u>2/26, 1969</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Donald F. Lewis M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-21-69.	
22d. PHYSICIAN'S NAME (Type) Dr. Donald Lewis		22e. ADDRESS 700 Cloverly St.		22f. CITY AND STATE SILVER SPRING MD.							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3-25-69		23c. NAME OF CEMETERY OR CREMATORY Church Cemetery,		23d. LOCATION (City or Town) (County) (State) Sandy Spring, Md.					
24. FUNERAL DIRECTOR Robert S. Saunders		ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR MAR 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (2)
30M. REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04132					04126				
1. DECEASED-NAME (Type or print) First Middle Last					2a. DATE OF DEATH			2b. HOUR	
Estelle Johnson					3 Month 8 Day 69 Year			2:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Female		Negro		3-20-1909		59 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
S.C.		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Wheaton		University Nursing Home		Caterer					
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
D.C.		V		Washington				4928 7th St., NW	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last							
Burkley		Estelle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		220-38-2777		MR. JAMES JOHNSON		4928 7th St. N.W. D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the breast with disseminated metastases</i> 174 X DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>4/20</i> , 19 <i>67</i> , to <i>3/8</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/8</i> , 19 <i>69</i> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Myron L. Lenkin</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/8/69</i>			
22d. PHYSICIAN'S NAME (Type) Myron L. Lenkin				22e. ADDRESS 2309 Shorefield Rd., Wheaton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
		3-12-69		Harmony Mem. Park		LANDOVER		Prince Geo. Md.	
24. FUNERAL DIRECTOR <i>Hall Bros. 621 Fla. Ave. N.W.</i>				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
						DATE MAR 12 1969			

26140

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04127					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										04127					
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR				
Mary			A.		Johnson				Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input checked="" type="checkbox"/> 3-4-69		M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			
Female		White		6-15-13		55 YRS.		MONTHS		DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH						2d. HOUR			
Penn.		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery						19 3:38 P.M.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring				8818 Glenville, Rd.				Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.				Montgomery				Sil. Spr.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8818 Glenville Rd.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
First Middle Last				First Middle Last											
Frank				01a				Mary							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
no				(If yes give war or dates of service)				579-10-40321A				Patricia Kinsey Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) 4123															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) Arteriosclerotic Heart Disease															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
Congestive Heart Failure															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				HOUR A.M. P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED							
Belden R. Reap				M.D.				March 4, 1969							
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER											
BELDEN R. REAP, M.D.				ADDRESS (Street, City, State, or County)											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				3-6-69				Arlington National				Arlington Virginia			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Francis J. Collins				DATE				MAR 10 1969				J. Charles Judge			
500 University Blvd. W. Sil. Sp. Maryland/															

04133

MAR 10 2003 01 19 AM

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04134

04128

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <i>Francis R. Johnston</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <i>3</i> Day <i>15</i> Year <i>1969</i>			2b. HOUR OF DEATH <i>1:45</i> M		
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>9-15-1922</i>	6. AGE (In years last birthday) <i>46</i> YRS.	IF UNDER 1 YEAR MONTHS <i>46</i>	IF UNDER 24 HRS. HOURS <i>46</i>	2c. DATE PRONOUNCED DEAD Month <i>March</i> Day <i>15</i> Year <i>1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Gaithersburg</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washingtonia Golf & Country</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>PRINTER</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Mont.</i>			13c. CITY OR TOWN <i>Bethesda</i>		
14. FATHER'S NAME First <i>FRANCIS</i> Middle <i>JOHNSTON</i> Last <i>JOHNSTON</i>			15. MOTHER'S MAIDEN NAME First <i>SAYLOR</i> Middle <i>JOHNSTON</i> Last <i>JOHNSTON</i>			16. SOCIAL SECURITY NO. <i>181-12-5100</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>			16b. SOCIAL SECURITY NO. <i>181-12-5100</i>			17. INFORMANT <i>CLAIRE D. JOHNSON, WIDOW.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarct, acute</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4109</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John E. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <i>March 16, 1969.</i>		
EXAMINER'S NAME (Type)			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>3-18-1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		
23d. LOCATION (City or Town) (County) (State) <i>Arlington County, Virginia</i>			24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</i>			25a. REC'D BY REGISTRAR DATE <i>MAR 20 1969</i>		
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								

84132

UNITED STATES DEPARTMENT OF HEALTH
MEDICAL EXAMINER, DISTRICT OF COLUMBIA

1951

ARLINGTON, VIRGINIA

ARLINGTON, VIRGINIA

1-18-52

1-18-52

JOHN DAVENPORT, JR., M.D. DIST. WASH.

1-18-52

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151 (1-68)
30M REV. 1-68

04135				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04123			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR				
BABY		Boy	Johns	Twin I	March 1 Day 1969 Year		8:47A				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		March 1, 1969		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		United States				Montgomery				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospital									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Montgomery		Kensington				11332 Mitscher Street			
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost		
William E				Johns	Jeanne				Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
				Father							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity First Twin DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from March 1, 1969, to March 1, 1969, that (I) (we) last saw the deceased alive on March 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
T.A. Cook		2 March 69		T.A. Cook		384 Univ. Blvd W, Sp. Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Cremation		3/3/69		Cedar Hill		Prince George Co. Md.					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Tyson Wheeler Funeral Home Rockville, Maryland		MAR 4 1969		Johns							

2540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04136		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04124		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
BABY			Boy		Johns	March 1 1969		9:45 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		March 1, 1969		YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.
Maryland		United States				Montgomery		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring		Holy Cross Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Montgomery		Kensington				11332 Mitscher Street
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		
William E.					Johns	Jeanne Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		
						Father		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity, Twin 777X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from March 1, 1969, to March 1, 1969, that (I) (we) last saw the deceased alive on March 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE T.A. Cook, M.D.						22c. DATE SIGNED 2 March 69		
22d. PHYSICIAN'S NAME (Type) T.A. Cook, M.D.						22e. ADDRESS 344 W. Beltsville Rd. Md.		
23a. BURIAL, CREMATION, Cremation		23b. DATE 3/3/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) Prince George Co.		(County) (State) Md.
24. FUNERAL DIRECTOR Lyon Wheeler						25a. REC'D BY REGISTRAR MAR 4 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

04138

UNITED STATES DEPARTMENT OF AGRICULTURE

04138

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "UNITED STATES" and "DEPARTMENT OF AGRICULTURE" are faintly visible.]

[Faint text at the bottom of the page, possibly a signature or footer, including the words "UNITED STATES" and "DEPARTMENT OF AGRICULTURE".]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 5, 6, 14 & 15

Film 410 3/17/69 kk

04137

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04129

1. DECEASED NAME (Type or Print) Florence Elizabeth Jones		Middle Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month 3 Day 8 Year 1969		2b. HOUR 1:15 P.M.	
3. SEX Female	4. RACE Cauc	5. DATE OF BIRTH 12/23/1902	6. AGE (In years last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month 3 Day 8 Year 1969	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2304 Blueridge Ave.							
14. FATHER'S NAME First Middle Last John Sam Samuel Boswell		15. MOTHER'S MAIDEN NAME First Middle Last Bertha Elizabeth Hamilton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 577-20-6593		17. INFORMANT ADDRESS Betty Villiotti 11526 Soward D. Whea			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) 301 W. Preston St., Baltimore, Md.		22b. DATE SIGNED March 8, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 11, 1969		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Francis J. Collins		ADDRESS 500 University Blvd. W. Silver Spring, Md.		25. RECEIVED BY REGISTRAR DATE MAR 12 1969		25b. REGISTRAR'S SIGNATURE James J. J...	

76120

Figure 1

1951-52

only 1000 copies.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04138									
04130									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Sophie</i> First <i>Ann</i> Middle <i>Kasmin</i> Last			2a. DATE OF DEATH <i>5</i> Month <i>3</i> Day <i>1969</i> Year			2b. HOUR <i>11:58 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>Caus.</i>		5. DATE OF BIRTH <i>6-30-1892</i>		6. AGE (In years lost birthday) <i>76</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Wheaton, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Ann Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>DC</i>		13b. COUNTY <i>Wash</i>		13c. CITY OR TOWN <i>DC</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4201 Cathedral Ave. N.W.</i>	
14. FATHER'S NAME <i>OSCAR</i> First <i>SCHWARTZ</i> Middle <i>UNKNOWN</i> Last			15. MOTHER'S MAIDEN NAME <i>UNKNOWN</i> First <i>UNKNOWN</i> Middle <i>UNKNOWN</i> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>0-88-20-7793</i>		17. INFORMANT <i>Sidney Kasimir</i>		Address <i>4201 Cathedral Ave., N.W. Washington, D. C.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> <i>4123</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>yes</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 YRS.</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Cerebral Senility - Compression Fr of Lumbar Vertebrae</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>3/13</i> , 19 <i>68</i> , to <i>4/5/69</i> , that (I) (we) lost saw the deceased alive on <i>3/31</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R.T. Benack MD</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <i>R.T. Benack MD / M. White MD</i>				22e. ADDRESS <i>4115 Colie Dr. Wheaton, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>Apr. 2, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King David Memorial Garden</i>		23d. LOCATION (City or Town) (County) (State) <i>Falls Church, Virginia</i>			
24. FUNERAL DIRECTOR <i>Donald M. Stein</i>				ADDRESS <i>232 Carroll</i>		25a. REC'D BY REGISTRAR <i>APR 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
Hebrew Memorial Funeral Home St., N.W. Wash., D.C.									

04130

DEPARTMENT OF HEALTH

04130

APR 5 1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04139									
CERTIFICATE OF DEATH									
04131									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Mary			E. Kelly			March Month 28 Day 1969 Year			M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR
Female		White		11-12-78			90 YRS.		MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Kansas		U.S.A.					Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Kensington			11006 Newport Mill Rd.			Retired			U.S. Gov.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?
Maryland			Montgomery			Kensington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
First Middle Last			First Middle Last						
Amos Pruitt			Caroline Bare			11006 Newport Mill Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
(If yes give war or dates of service)			217-46-5802			Mrs. Cathrine O'Connor			Same as #13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>									4/23/69
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u>									4/10/69
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
<u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>58</u> , to <u>March</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>March 28</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
<u>Rolph E. Tatter</u>									<u>3/28/69</u>
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
<u>ROLPH E. TATTER</u>					<u>1407 Woodside Parkway</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		3-31-69		Fort Lincoln			Bladensburg, Maryland		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Francis J. Collins					500 University Blvd. W. Silver Spring, MD.		DATE <u>APR 1 1969</u> <u>J. Charles Judge</u>		

04130

EXHIBIT 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)
30M REV. 7-68

04140		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04132					
1. DECEASED-NAME (Type or print)		First ADA		Middle KEMPER		Last KEMPER		2a. DATE OF DEATH Month 23 Day 69 Year		2b. HOUR 2:00 PM	
3. SEX F		4. RACE NEGRO		5. DATE OF BIRTH 9-1-86		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) ARLINGTON Va		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNIVERSITY NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived/ if institution: Residence before admission) STATE D.C.		13b. COUNTY 13c. CITY OR TOWN 909 R St. N.W. WASHINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT MRS. A. GRANT		Address 909 R St. N.W. WASHINGTON D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Metastatic CA of the BREAST DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 3/13, 1969, to 3/23, 1969, that (I) (we) last saw the deceased alive on 3/18, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]		22c. DATE SIGNED 3/23/69		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-29-69		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Br. Soc. Cemetery Md		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR Sally Funeral Home 7831 2nd Ave NW		ADDRESS		25a. REC'D BY REGISTRAR MAR 27 1969		25b. REGISTRAR'S SIGNATURE [Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04141 CERTIFICATE OF DEATH 04133										
1. DECEASED-NAME (Type or print)			First Middle Last Michelle Rene KENT			2a. DATE OF DEATH Month Day Year March 25 69			2b. HOUR 1055 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH March 13, 1969			6. AGE (In years last birthday) YRS. MONTHS DAYS 12		IF UNDER 1 YEAR DAYS 12	
7a. BIRTHPLACE (State or foreign country) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE S. Carolina			13b. CITY OR TOWN Charleston		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1924 B Mosstree Road			
14. FATHER'S NAME First Middle Last Michael B. Kent			15. MOTHER'S MAIDEN NAME First Middle Last Shirley Tilson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Charleston SGT Michael B. Kent, USAF		Address S. Carolina 1924 B Mosstree Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAL ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGENITAL HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>Mar. 22</u> , 19 <u>69</u> , to <u>Mar. 25</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>Mar. 25</u> , 19 <u>69</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <u>J. K. Howe M.D.</u>					DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Mar. 26, 1969	
22d. PHYSICIAN'S NAME (Type) J. K. Howe, M.D.					22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL, OR OTHER Disposition Burial		23b. DATE 3-27-69		23c. NAME OF CEMETERY OR CREMATORY Beaufort National Cemetery Beaufort			23d. LOCATION (City or Town) (County) (State) S.C.			
24. FUNERAL DIRECTOR Robert A. Humphrey 7557 Wisconsin Ave. Bethesda, Md.					25a. REC'D BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

0444

0-1130

DEPARTMENT OF DEFENSE

NAME: [illegible] GRADE: [illegible] BRANCH: [illegible] DATE: [illegible]

REMARKS: [illegible]

1. [illegible] 2. [illegible] 3. [illegible]

4. [illegible] 5. [illegible] 6. [illegible]

7. [illegible] 8. [illegible] 9. [illegible]

10. [illegible] 11. [illegible] 12. [illegible]

13. [illegible] 14. [illegible] 15. [illegible]

16. [illegible] 17. [illegible] 18. [illegible]

19. [illegible] 20. [illegible] 21. [illegible]

22. [illegible] 23. [illegible] 24. [illegible]

25. [illegible] 26. [illegible] 27. [illegible]

28. [illegible] 29. [illegible] 30. [illegible]

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40. [illegible] 41. [illegible] 42. [illegible]

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46. [illegible] 47. [illegible] 48. [illegible]

49. [illegible] 50. [illegible] 51. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner of Maryland 3/15/69

VR A15
45M - 1069

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04142									
CERTIFICATE OF DEATH									
04134									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
David			none King			March 15 69		8:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Negro		Separate 12/20/1901		67 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Oklahoma		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Wheaton			Univ. Nurs. Home			Custodian			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Washington, DC			136. COUNTY				115 W St., NW		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Lawrence ?			King ?			Emma ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			718-12-2042A		George Temme 901 Arcola Ave. Wheaton				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 4379									
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/5, 1969, to 3/13, 1969, that (I) (we) last saw the deceased alive on 3/13, 1969, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Allan Cohan, M.D.					13515 Georgia Ave., Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
3-24-69			3-24-69		Hammory		Sandover, Maryland		
24. FUNERAL DIRECTOR'S NAME (Type)					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROLLINS FUNERAL HOME, INC.					DATE		MAR 24 1969		
4339 HUNT PLACE, N. E.							Charles Judge		

02143

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, NEW YORK STATE

NAME	LAST, FIRST, MIDDLE
AGE	AT DEATH
SEX	
RACE	
DATE OF BIRTH	
PLACE OF BIRTH	
DATE OF DEATH	
PLACE OF DEATH	
CAUSE OF DEATH	
DIAGNOSIS	
DATE OF EXAMINATION	
PLACE OF EXAMINATION	
NAME OF PHYSICIAN	
SIGNATURE OF PHYSICIAN	
NAME OF WITNESS	
SIGNATURE OF WITNESS	
NAME OF FUNERAL DIRECTOR	
SIGNATURE OF FUNERAL DIRECTOR	

1941, Death in N.Y., Silver Spring, Md.

1941, Death in N.Y., Silver Spring, Md.

ROLLINS FUNERAL HOME, INC.
4555 HUNT PLACE N.E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Charged with Medical Examiner

04143		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04135	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
MAYNARD				WILSON	KING	3 27 69 12 noon	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Male		White		March 11/03		66 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		USA				Montgomery Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring Md.		Holy Cross Hospital		salesman		realestate	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Montgomery		Sil. Sprg.		13e. STREET AND NUMBER	
						1809 Powder Mill Rd. SSMd	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
James R. King						Della Woodfield	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		
no			578-50-6548		E. King wife Ruth 1809 Powder Mill Rd. SSMd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio sclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4123</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u> <u>years.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>69</u> , to <u>Mar</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Mar</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>James R Coleman MD</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>MARCH 27, 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>JAMES R COLEMAN</u>				22e. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		March 31, 1969		Fort Lincoln Cemetery		Washington, D. C.	
24. FUNERAL DIRECTOR <u>P. S. Smith</u>				25a. REC'D BY REGISTRAR <u>APR 1 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Warner E. Pumphrey, Inc. Silver Spring, Maryland							

06130

DATE TIME

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04145		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04137	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
Helen			Stratton	Klein	3 8 69		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female		Caucasian		Mar. 22, 1897		71 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Colorado		U.S.A.				Montgomery	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Althea Woodland Mrs. Home - 1000 Daleview Dr.		AT HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Washington, D.C.				Washington, D.C.		13e. STREET AND NUMBER	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	
Chester		Jane		No		-	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		19. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Gen. John A. Klein, HUSBAND,							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Nov 27, 1967, to Mar 8, 1969, that (I) (we) last saw the deceased alive on Mar 8, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
Bernard A. Fitzgerald		3-8-69		BERNARD A. FITZGERALD			
22e. ADDRESS		22f. REC'D BY REGISTRAR		22g. REGISTRAR'S SIGNATURE			
217 Univ. Blvd E Bldg. 12		MAR 14 1969		Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		3-12-1969		ARLINGTON NATIONAL		ARLINGTON COUNTY, VIRGINIA	
24. FUNERAL DIRECTOR		25a. ADDRESS		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
Joseph Gambino Sons		5130 W. 1st Ave.		MAR 14 1969		Charles Judge	

06145

ARTICLE OF DEATH

0110

Name of Deceased		Date of Death	
Place of Death		Cause of Death	
Age at Death		Sex	
Marital Status		Occupation	
Education		Religion	
Last Residence		Previous Residence	
Family History		Social History	
Medical History		Mental History	
Autopsy Results		Burial Information	
Witnesses		Signature of Doctor	
Signature of Registrar		Date of Registration	

04146

CERTIFICATE OF DEATH

04138

1. DECEASED-NAME (Type or print) <i>Robert</i>		First <i>Robert</i>	Middle <i>F.</i>	Last <i>Klepinger</i>	2a. DATE OF DEATH Month <i>March</i> Day <i>24</i> Year <i>1969</i>		2b. HOUR <i>7:15 A</i>
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Aug 12, 1903</i>		6. AGE (In years last birthday) <i>65</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Ohio</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Attorney</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Law</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>Carson</i> Middle <i>W.</i> Last <i>Klepinger</i>		15. MOTHER'S MAIDEN NAME First <i>Bessie</i> Middle <i>Jenner</i> Last <i>Jenner</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>094-22-9846</i>		17. INFORMANT Address <i>Mona A. Klepinger, widow</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>4123</i> <i>Coronary Artery Disease</i>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <i>Arteriosclerotic C.V. Disease</i> <i>years</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
<i>Diabetes Mellitus - Mesenteric Thrombosis</i>							
19a. DATE OF OPERATION <i>3-23-69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Mesenteric Thrombosis</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1966</i> , to <i>24 Mar</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>24 March 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>DeWitt E. DeLauter MD</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-24-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>DeWitt E. DeLauter</i>				22e. ADDRESS <i>3848 Porter St NW Wash D.C.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>3-26-1969</i>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <i>Granville, Ohio</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 5150 Wisc. Ave. N.W., Wash., D.C., 20016</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 26 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04140

REPORT

REPORT

Removal, Ohio

3-25-1969

Removal

Joseph Davis's name is . . . 2130 Wind. Ave.

2 . . . 20016

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First HELEN		Middle Spangler		Last Didot		2a. DATE OF DEATH		2b. HOUR	
								Month 3		Day 31	
								Year 69		2b. HOUR 12 A	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 4/9/96		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) TENN.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE VA		13b. COUNTY Hanover		13c. CITY OR TOWN Mechanicsville		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER Eastern View Rt.#1			
14. FATHER'S NAME		First UNK		Middle SPENGLER		Last UNK		15. MOTHER'S MAIDEN NAME		First UNK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 229-68-0662T		17. INFORMANT SON		Address -8417 MILFORD AVE, S.S., MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830 DUE TO, OR AS A CONSEQUENCE OF (b) carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) carcinoma of ovary										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WKS WKS. WKS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CORONARY ARTERY DISEASE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 2/12, 1969 , to 3/30, 1969 , that (I) (we) last saw the deceased alive on 3/30, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Albert H. Grollman MD		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/31/69					
22d. PHYSICIAN'S NAME (Type) ALBERT H. GROLLMAN		22e. ADDRESS 1106 SPRING ST. SILVER SPRING									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 1, 1969		23c. NAME OF CEMETERY OR CREMATORY Woodland Cemetery		23d. LOCATION (City or Town) (County) (State) Ashland, Virginia					
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		24a. ADDRESS 434 Georgia Avenue		25a. REC'D BY REGISTRAR Charles Judge		DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Betty Rappaport, M.D. Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Irene		B		Lanchester				3 Month 28 Day 69 Year		1239	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS	
female		w. cac.		11/3/1897		71 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Colorado		US				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospital		housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md		Montg.		Silver Spr.				10805 Huntley Place			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Max		NMI		Briegle				Mary		I Thoroloway	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no		217-48-3596		Horace P.		10805 Huntley Pl., SS., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>										1 hr.	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Essential Hypertension</u>										years	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Atherosclerosis</u>										years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Cerebral Thrombosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 1/10/53 to 3/28/69, that (I) (we) lost saw the deceased alive on 3/22/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<u>Henry J. Curry</u>				<input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Cremation		3/29/1969		Lee's Crematory		300 4th St. N.E. Wash. D.C.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Lee Funeral Home, 300 4th St. NE, Wash, D.C.				APR 2 1969		<u>Charles Judge</u>					

DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15
45M - 1/69

04149		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04141			
1. DECEASED-NAME (Type or print) <i>Benjamin H. LARman.</i>						2a. DATE OF DEATH Month <i>3</i> Day <i>26</i> Year <i>69</i>		2b. HOUR <i>4:28 PM</i>	
3. SEX <i>MALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>4-25-07</i>		6. AGE (In years lost birthday) <i>61</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery.</i>			
10. CITY OR TOWN OF DEATH <i>Bethesda.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Landscaping</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Boys</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Box #218</i>	
14. FATHER'S NAME First <i>George</i> Middle <i>LARman.</i> Last <i>Bessie.</i>		15. MOTHER'S MAIDEN NAME First <i>Monard.</i> Middle <i>Monard.</i> Last <i>Monard.</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>218-07-2384</i>		17. INFORMANT <i>Alice Hawse - 15yds md.</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Bronchogenic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION <i>3/25/69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Breast obstruction</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>3/20</i> , 19 <i>69</i> , to <i>3/26</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/26</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Orville Spier MD</i>		22c. DATE SIGNED <i>3/27/69</i>		22d. PHYSICIAN'S NAME (Type) <i>Orville Spier MD</i>					
22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE <i>3/29/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Monocacy</i>		23d. LOCATION (City or Town) (County) (State) <i>Beallsville Monty. Md</i>			
24. FUNERAL DIRECTOR <i>William B. Hilton, Barnesville, Md</i>		25a. REC'D BY REGISTRAR <i>APR 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>W. Charles Judge</i>					

00149

STATE OF CALIFORNIA

00149



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please leave carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/6

04150

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04142

1. DECEASED-NAME (Type or print) <i>William Jennette Leaman</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>21</i> Year <i>69</i>			2b. HOUR <i>5:03 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>June 12, 1899</i>		6. AGE (In years last birthday) <i>69</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Foranac Valley Day Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Clarksburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First <i>William</i> Middle <i>Henson</i> Last <i>Leaman</i>		15. MOTHER'S MAIDEN NAME First <i>Susie</i> Middle <i>J.</i> Last <i>Millard</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Miss Rebecca Leaman</i>		Address <i>Germanstown Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> <i>1579</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastatic Ca.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ca. of Pancreas</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>6 mos</i> <i>1 yr</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Diabetic Mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/10</i> , 19 <i>55</i> , to <i>3/21</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/21</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen H. Jones M.D.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/21/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>R</i>				22e. ADDRESS <i>Rockville, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/25/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Methodist</i>		23d. LOCATION (City or Town) (County) (State) <i>Clarksburg Montg. Md.</i>	
24. FUNERAL DIRECTOR <i>W. B. Hilton</i>		ADDRESS <i>Barnsville Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 28 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William Judge</i>	

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FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04151										
Item 23 Film 410 3/14/69 kk										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last NAOMI ELIZABETH LEE					2a. DATE OF DEATH Month Day Year MARCH 5 1969			2b. HOUR 9:30 A M		
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH 13 MARCH 1931		6. AGE (In years last birthday) 37 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL, BETHESDA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RECORD ANALYST		12b. KIND OF BUSINESS OR INDUSTRY NAVY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE VIRGINIA			13b. CITY OR TOWN ARLINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1216 S. ROLFE ST.			
14. FATHER'S NAME First Middle Last BERNARD MORTON			15. MOTHER'S MAIDEN NAME First Middle Last HATTIE E. LOCKETT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 570 36 3524		17. INFORMANT WILLIAM M. LEE				Address 1216 S. ROLFE ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma breast with metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (A) (this hospital) attended the deceased from 13 FEB. 1969, to 5 MARCH 1969, that (A) (we) last saw the deceased alive on 5 MARCH 1969, and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (not) view the body after death.										
22b. SIGNATURE Michael D. Gorman, M. D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5 MARCH 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-10-69		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) ARLINGTON, ARLINGTON, VA.				
24. FUNERAL DIRECTOR CHINN FUNERAL HOME				ADDRESS GLEBE RD., ARLINGTON, VA.		25a. REC'D BY REGISTRAR DATE MAR 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

04151

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APR 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

04152		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04144	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
BERNARD E. LESTER					MARCH 31 1969		10:50 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE	WHITE	7/26/29		39 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
W. VA.	U. S. A.			MONTGOMERY Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		SUBURBAN		LETTER CARRIER		U.S. Post Office	
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		MONTGOMERY		GERMANTOWN		13e. STREET AND NUMBER	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET AND NUMBER			
First Middle Last		First Middle Last		MIDDLEBROOK TRAILER COURT			
VAN LESTER		ANGIE P. BRIGGS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
YES 1951-55				IVORY LESTER - WIFE - SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adrenal Cortical Failure 1539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis (c) Carcinoma of Bowel							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 19 1969, to March 31, 1969, that (I) (we) last saw the deceased alive on 3/31 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
Robert A. Barnett MD		3-31-69		22e. ADDRESS			
				809 Viers Mill Road, Rockville, Md.			
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial Tran		4/4/69				Sophia, West Virginia	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home		1331 Rock Pike Rockville, Maryland		APR 7 1969		Charles Judge	

84152

OFFICE OF STATE

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[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

[Faint handwritten text at the bottom of the page, possibly a signature or date.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04153		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04145	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year	
MARY R. LEWIS						Mar. 14, 1969	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
Female		White		Aug. 25, 1883		85 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Minn.		U. S.				MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Chevy Chase		4712 Chevy Chase Blvd.		Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Montgomery		Chevy Chase		4712 Chevy Chase Blvd.	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME	
Albert E. Kaech						Ellen Ryan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address
No			524-62-8272J1		Sister Monica K. Payne		Same as Item 13.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u>							MINUTES
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							YEARS
DUE TO, OR AS A CONSEQUENCE OF (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>							YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
<u>CHRONIC RENAL INSUFFICIENCY WITH AZOTEMIA</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>AUG 9, 1966</u> , to <u>MAR 14, 1969</u> , that (I) (we) last saw the deceased alive on <u>MARCH 6, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.							
22b. SIGNATURE <u>George A. Tralka M.D.</u>						22c. DATE SIGNED <u>MARCH 15, 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>GEORGE A. TRALKA</u>						22e. ADDRESS <u>915-19th St., N. W. Washington, D. C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>Evergreen Burial</u>		<u>3-18-69</u>		<u>Evergreen Cemetery</u>		<u>Colorado Springs, Colo.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>MAR 20 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04153

INFORMATION DEPARTMENT

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

[The remainder of the page contains extremely faint, illegible text, likely bleed-through from the reverse side of the document.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

04154										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04146									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last										Month Day Year										A M									
Magdalen Frances Liammari										March 25 1969										7:50 M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Female			White			5 January 1916			53 YRS.			MONTHS DAYS HOURS MIN																	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Minnesota			USA						Montgomery						Md.														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Bethesda			The Clinical Center			housewife																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
Virginia						Falls Church						2926 Lockport Drive																	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																										
First Middle Last			First Middle Last																										
Joseph Zitzmann			Rose Ourada																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMATION																							
Yes			1942-46			475-07-9099			The Medical Records Address																				
						The Clinical Center, NIH, Bethesda, Md. 20014																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Asphyxia secondary to aspiration of vomitus</u>										5 minutes																			
2001 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) <u>Lymphosarcoma</u>																			
										3 years																			
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					yes														
21a. ACCIDENT WAS UNDERLYING					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																													
22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>6 March</u> , 19 <u>69</u> , to <u>25 March</u> , 19 <u>69</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>25 March</u> , 19 <u>69</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(X)</u> (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										22c. DATE SIGNED																			
<u>Clarence H. Brown, M.D.</u>										25 March 1969																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
Clarence H. Brown, M.D.										The Clinical Center, National Institutes of Health, Bethesda, Md. 20014																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					Mar. 28, 1969					National Memorial Park					Falls Church, Fairfax, Va.														
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Pearson's Funeral Home										Falls Church Va										MAR 27 1969									

STATE OF NEW YORK

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notified Dr. Reap

1

04155

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04147

1. DECEASED-NAME (Type or print) First Middle Last <i>Helton G Littleford</i>			2a. DATE OF DEATH Month Day Year <i>3 4 69</i>			2b. HOUR <i>2:30 P</i>					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>February 27, 1897</i>		6. AGE (In years last birthday) <i>72</i>		IF UNDER 1 YEAR MONTHS DAYS <i>0 8</i>		IF UNDER 24 HRS. HOURS MIN. <i>0 0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Kensington</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>2609 McComas Avenue</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife - own home</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kensington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2609 McComas Avenue</i>		
14. FATHER'S NAME First Middle Last <i>Richard Windsor</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Rose Hutchinson</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>215-34-3116</i>		17. INFORMANT <i>Mr. Robert R. Bladen</i> Address <i>2609 McComas Avenue Kensington, Maryland</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of stomach</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <i>Jan. 23, 1969</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of stomach</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>July 4, 1935</i> , to <i>March 4, 1969</i> , that (I) (we) last saw the deceased alive on <i>Feb. 21, 1969</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Katharine R. Chapman, M.D.</i>						DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>March 5, 1969</i>	
22d. PHYSICIAN'S NAME (Type) <i>Katharine Chapman</i>						22e. ADDRESS <i>3924 Baltimore Ave. Kensington, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>March 8, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Rockville Montgomery Md.</i>			
24. FUNERAL DIRECTOR <i>C. Glen Carter</i> ADDRESS <i>8434 Georgia Avenue</i>						25a. REC'D BY REGISTRAR <i>Warner E. Pumphrey, Inc.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15-10 45M - 1-69						DATE <i>MAR 10 1969</i>					

04125

CERTIFICATE OF MARRIAGE

STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
04156			04148						
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
MARY AGNES			LIVERETT			MARCH 22 1969			6 30
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR
Female		White		June 16 1906			62		MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH	
Maryland		USA		WIDOWED		DIVORCED		MONTGOMERY	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Suburban Hosp.			Housewife			at home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Md			Pr. George		Glasgow		YES NO		309 Audrey Lane
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Unknown			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			578-22-9816		George R. Liverett				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
180 X <u>due to recurrent squamous cell carcinoma, cervix</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>2 1/2 years.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. Month Day Year						
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Oct 1966, to 3/22 1969, that (I) (we) last saw the deceased alive on 3/21 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
Frederick Y. Donin			3/22/69						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
FREDERICK Y. DONIN			800-4th St. S.W. D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			3-25-69		Washington National		Suitland, Maryland		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. W. Chambers			577-11th St. S.E.			MAR 26 1969		Charles Judge	

04120

OFFICE OF DEATH

MADE IN THE U.S.A. BY THE U.S. GOVERNMENT PRINTING OFFICE

one to record and one to preserve, service
of the

MAY 2 1960

04157

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04149

FOR STATE
HEALTH DEPT.

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year				2b. HOUR
William			D	Lucas	ESTIMATED <input type="checkbox"/> March 26 1969				7:42 M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD
male	White	2/21/22		47 YRS.	MONTHS	DAYS	HOURS	MIN	March 26 1969 7:42 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Kansas		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hosp				Retired		Real Estate	
13a. USUAL RESIDENCE (Where deceased lived, if by institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER	
MD		Mont		Cherry Chase				5419 Centex St.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Cecil J.				Lucas	Nell				Kendrick
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
YES		WWII KOREAN		514-07-2236		Wife Mrs. W.D. Lucas Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Subdural hematoma, right cerebral hemisphere									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				9 P.M. 9 19		P.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
		P.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		JOHN G. BALL				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		March 26, 1969	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3-29-69		Gate of Heaven Cem.		Silver Spring, Maryland			
24. FUNERAL DIRECTOR		Bethesda, Md. ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Humphrey		7552 Wisconsin Ave				APR 1 1969		Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03130

U.S. DEPARTMENT OF AGRICULTURE

UNIT 1

UNIT 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04158

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04150

1. DECEASED-NAME (Type or print)			First <i>Byron</i>	Middle <i>L</i>	Last <i>Lutz</i>	2a. DATE OF DEATH Month <i>5</i> Day <i>13</i> Year <i>69</i>			2b. HOUR <i>10:11 P.M.</i>
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Aug 19 1890</i>		6. AGE (In years lost birthday) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Pu.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Wheaton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Randolph Hills Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i> Auditor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>			
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>Md</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Chesapeake</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3914 Aspen Street</i>	
14. FATHER'S NAME First <i>John</i> Middle <i>Monroe</i> Last <i>Lutz</i>			15. MOTHER'S MAIDEN NAME First <i>Alma</i> Middle <i>Welch</i> Last <i>Welch</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>214-34-6987</i>		17. INFORMANT <i>Arlene Plotz</i>		Address <i>3914 Aspen St Chesapeake, Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Nephrosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis, genl.</i> 403X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 Wks</i> <i>5 yrs, 6 mos</i> <i>15 yrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1) Cerebral vascular accident, 2) Arterial embolism, rt lower leg</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <i>69</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>68</i> , to <i>Mar. 13</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Mar. 12</i> , 19 <i>69</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Philip H. Varner, M.D.</i>		22c. DATE SIGNED <i>3-13-69</i>		22d. PHYSICIAN'S NAME (Type) <i>Philip H Varner Md</i>					
22e. ADDRESS <i>10620 Georgia Ave Wheaton, Md</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-17-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville Mont. Md</i>			
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>		24b. ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>		25b. REC'D BY REGISTRAR <i>MAR 19 1969</i>		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

06158

RECEIVED

1954

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Horace Thomas MACEY Jr.						Month Day Year		808 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD	
Male	Cauc	July 31, 1916	52 YRS.					Month Day Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR	
Maryland		USA				Montgomery		808 PM	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Naval Hospital			U. S. Navy			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland			Anne Arundel			Pasadena		Rural Route 14, Box 20	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Horace Thomas MACEY Sr.			Harriet D. Howard						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
yes			1936-55			Baltimore, Md.			
						Horace T. Macey, III, 3230 Rolling Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Confluent Broncho-Pneumonia</u>									<u>1 week</u>
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Status Post Operative Repair of Abdomen/Wounds 19 days</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Gun Shot Wounds of Abdomen</u>									<u>19 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY?	
3/7/69				Repair of Abdomen/Wounds				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			4:15 P.M. 7 Mar 19 69		Shot in abdomen with 12 gauge shotgun				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County				
		home			Route 14, Box 20 Pasadena, Anne Arundel Md. State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
John G. Ball						27 March 1969			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
John G. Ball, M. D.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		4-1-69		Baltimore National Cemetery Baltimore			Maryland		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Barranco Funeral Parlor						DA APR 2 1969		Charles J. J...	
Severna Park, Maryland									

RECEIVED
JULY 11 1953

DATE

MEMORANDUM FOR THE CHIEF OF BUREAU

04-101

TO: SAC, NEW YORK
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum detailing an investigation or report.]

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 412 MARYLAND STATE DEPARTMENT OF HEALTH
5-14-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04160

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04152

1. DECEASED-NAME (Type or Print) FRED First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 - 16 Day 16 Year 1969			2b. HOUR 4:20 AM		
3. SEX M	4. RACE W	5. DATE OF BIRTH 8-4-18	6. AGE (In years last birthday) 50 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD 3-16-69 Month 3 Day 16 Year 1969		
7a. BIRTHPLACE (State or foreign country) N.D.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH TAKOMA PARK,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH SAN AND HOSP				12a. USUAL OCCUPATION (Kind of work done during last year or life available) Public Works		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY MONT.		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 7403 MAPLE AVE								
14. FATHER'S NAME FRED First Middle Last MAGNUS			15. MOTHER'S MAIDEN NAME ANNETTA First Middle Last HARMON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO.		17. INFORMANT HOSP RECORD ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 431.9 IMMEDIATE CAUSE (a) Massive acute intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) associated with Hemophilia DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Neap M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 3/16/1969		
EXAMINER'S NAME (Type) BELDEN R. NEAP M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS Colmar Manor Pk. Dr. Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE March 17, 1969		23c. NAME OF CEMETERY OR CREMATORY For Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pk. Dr. Md.		
24. FUNERAL DIRECTOR Takoma Funeral Home Inc. J.A. Walters ADDRESS 254 Carroll Dr N.W.T.				25a. RECEIVED BY REGISTRAR MAR 19 1969 DATE		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

04160 MEDICAL EXAMINATION CERTIFICATE OF HEALTH

NAME

DATE

AGE

SEX

PLACE OF BIRTH

EDUCATION

PRESENT ADDRESS

DATE OF EXAMINATION

BY

PHYSICIAN

REMARKS

INITIALS

SIGNATURE

DATE

PLACE

STATE

CITY

COUNTY

ZIP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04161		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		04153							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR				
Francis E. Maloney						May 14 1969			11:45 PM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
male		white		3/9/97			72						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Nebraska			USA				Montgomery						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda			Suburban Hospital			REAL ESTATE			GEORGE T. BAIGER				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Maryland			Montgomery		Chevy Chase				6915 Ridgewood Ave				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last				
Patrick Paul Maloney						Mary Torpy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give way or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address							
YES WWI						Elizabeth Maloney - wife - old same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Jan 1964, to May 14, 1969, that (I) (we) saw the deceased alive on May 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS	
James J. Foster M.D.			3/14/69			James J. Foster						915 19th N.W. Washington, DC	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			3-18-69		Gate of Heaven Cem.			Silver Spring, Maryland					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
ROBERT A. PUMPHREY, Bethesda, Maryland						MAR 20 1969		Charles Judge					

1250

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04162

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04154

1. DECEASED-NAME (Type or print) BERTHA E MANN			2a. DATE OF DEATH March Month 6 Day 1969			2b. HOUR 2A M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 12, 1880		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS 10 DAYS 24		IF UNDER 24 HRS HOURS 10 MIN 24	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nurs. Home		12a. USUAL OCCUPATION (Kind of work done during most of life, if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland STATE Montgomery COUNTY		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 100 Dale Drive, Rockville Maryland					
14. FATHER'S NAME First Charles W. Creek Middle Charles W. Creek Last Charles W. Creek				15. MOTHER'S MAIDEN NAME First Sarah Middle Mallott Last Sarah							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. -----		17. INFORMANT Boyd H. Mann - son - same item # 13 Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 486X Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 486X DUE TO, OR AS A CONSEQUENCE OF (c) 486X										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Long Term Congestive Heart Failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from out , 19 50 , to March , 19 69 , that (I) (we) last saw the deceased alive on March , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. S. Murphy MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED March 69			
22d. PHYSICIAN'S NAME (Type) William S. Murphy		22e. ADDRESS 615 W. Montgomery Ave., Rockville, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/8/69		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Pk		23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery, Md.					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 Rock. Pike Rockville, Maryland				25a. REC'D BY REGISTRAR DATE Mar 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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04163		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04155	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <u>James A Matthews</u>			2a. DATE OF DEATH <u>3</u> Month <u>30</u> Day <u>69</u> Year			2b. HOUR <u>1:55</u> M	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>10/3/1889</u>		6. AGE (In years last birthday) <u>79</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Penna</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>Wheaton</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Randolph Hills Nursing Home Rest. Owen</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Montgomery Bethesda</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>6614 Braeburn Parkway</u>	
14. FATHER'S NAME First <u>Levi</u> Middle <u>Matthew</u> Last <u>5</u>			15. MOTHER'S MAIDEN NAME First <u>Whelmy</u> Middle <u>Tinklebaugh</u> Last <u>8</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>579017332</u>		17. INFORMANT <u>WIFE</u> Address <u>ANNA MATTHEWS 6614-BRAEBURN PKWY</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary and Cerebral Embolism</u> <u>4349</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>27 hours</u> <u>10 years</u> <u>15 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 29, 1967</u> , to <u>Mar 30, 1969</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>March 30, 1969</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (<u>did not</u>) view the body after death.							
22b. SIGNATURE <u>R. Stephen Hulburt, M.D.</u> DEGREE 22d. PHYSICIAN'S NAME (Type) <u>R. STEPHEN HULBURT, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>March 30, 1969</u>	
22e. ADDRESS <u>3000 Dent Place, N.W.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>APR. 2, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>WHEATON MD.</u>	
24. FUNERAL DIRECTOR <u>John F. DeLoe</u> (DEVELOPER FUNERAL HOME)				25a. REC'D BY REGISTRAR DATE <u>APR 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED NAME (Type or print) <i>Lewis</i>			First <i>J.</i>			Middle <i>Matthews</i>			Last <i>Matthews</i>			2a. DATE OF DEATH Month <i>MARCH</i> Day <i>20</i> Year <i>1969</i>			2b. HOUR <i>6:45</i> M		
3. SEX <i>Male</i>			4. RACE <i>Caucasian</i>			5. DATE OF BIRTH <i>May 12, 1895</i>			6. AGE (In years last birthday) <i>73</i> YRS.			IF UNDER 1 YEAR MONTHS <i>13</i> DAYS <i>13</i> HOURS <i>13</i> MIN.			IF UNDER 24 HRS. HOURS <i>13</i> MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Wash., D. C.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>			Md.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>1905 Elkhart St.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired - Johns Hopkins Lab.</i>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Silver Spring</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>1905 Elkhart St.</i>					
14. FATHER'S NAME <i>Lewis</i>			First <i>J.</i>			Middle <i>Matthews</i>			Last <i>Matthews</i>			15. MOTHER'S MAIDEN NAME <i>Annie Williams</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>Yes</i>			(If yes give war or dates of service) <i>WW I</i>			16b. SOCIAL SECURITY NO. <i>yes</i>			17. INFORMANT <i>Elizabeth E. Matthews</i>			Address <i>1905 Elkhart St. Silver Spring, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCT</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>DIABETES MELLITUS</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 MINUTES</i> <i>20 YEARS</i> <i>4 YEARS</i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <i>Cerebral Arteriosclerotic Vascular Disease</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 7, 1969</i> to <i>MARCH 20 1969</i> , that (I) (we) lost saw the deceased alive on <i>MARCH 19 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																	
22b. SIGNATURE <i>George B. Patrick, Jr. MD</i>			DEGREE <i>MD</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>3-20-69</i>								
22d. PHYSICIAN'S NAME (Type) <i>George B. Patrick, Jr. MD</i>			22e. ADDRESS <i>9221 Colesville Rd. Silver Spring, Md.</i>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>3-24-69</i>			23b. DATE <i>3-24-69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>								
24. FUNERAL DIRECTOR <i>E. S. Smith</i>			ADDRESS <i>Waner E. Pumphrey, Inc. 8434 Ga. ave. Silver sp</i>			25a. REC'D BY REGISTRAR <i>DATE MAR 28 1969</i>			25b. REGISTRAR'S SIGNATURE <i>William A. Vugge</i>								

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04165

04157

1. DECEASED-NAME (Type or print) <u>Alivia Maxson</u>			2a. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>69</u>			2b. HOUR <u>3:15</u> PM					
3. SEX <u>Female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>10-20-77</u>		6. AGE (In years last birthday) <u>91</u> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____	
7a. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>America</u>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.					
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanitarium & Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>None</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>			13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Washington DC</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>7437 Keystone Lane</u>		
14. FATHER'S NAME First <u>Albert</u> Middle _____ Last _____			15. MOTHER'S MAIDEN NAME First <u>Melissa</u> Middle _____ Last <u>Clark</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>None</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>176-30-9457</u>		17. INFORMANT <u>Records - Washington Sanitarium & Hospital</u> Address _____						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>485x Branchial Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Debilitation with Acute Peritonitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Two Days</u> <u>Two Weeks</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure, Arteriosclerosis Generalized</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <u>19</u> P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____		State _____	
22a. I certify that (I) (this hospital) attended the deceased from <u>January, 1968</u> , to <u>March 21, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 21, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Stuart L Nelson MD</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3-21-69</u> Md			
22d. PHYSICIAN'S NAME (Type) <u>Stuart L Nelson MD</u>						22e. ADDRESS <u>831 University Blvd Silver Spring</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3-24-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Baptist</u>		23d. LOCATION (City or Town) (County) (State) <u>Dodderidge Cty, W. Va</u>					
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u> ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>						25a. REC'D BY REGISTRAR DATE <u>MAR 26 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

04165

04165

Approved for release by the National Security Council on 10-10-64
Authority: Executive Order 11652, February 2, 1957
This document contains information which is exempt from public release under
Executive Order 11652, February 2, 1957, and is to be controlled, stored,
transmitted, and disposed of in accordance with the provisions of that
order.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04166

04158

1. DECEASED-NAME (Type or print) ROBERT L. MAY			2a. DATE OF DEATH Month 3 Day 2 Year 69			2b. HOUR 4:20 M	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH 12/31/22		6. AGE (In years last birthday) 46 YRS.	IF UNDER 1 YEAR MONTHS 4 DAYS 10		IF UNDER 24 HRS. HOURS 4 MIN. 20
7a. BIRTHPLACE (State or foreign country) Ukraine	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) A Lawyer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 13527 VANDALIA DRIVE			
14. FATHER'S NAME First ROBERT L. Middle L. Last MAY			15. MOTHER'S MAIDEN NAME First ELIZABETH Middle L Last WEAVER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. SOCIAL SECURITY NO. 237-26-4262		17. INFORMANT MARY H. MAY, WIFE, SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF WITH LEFT VENTRICULAR RUPTURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY THROMBOSIS-OCCLUSION DUE TO, OR AS A CONSEQUENCE OF CIRCUMFLEX BRANCH, LEFT CORONARY A. (c) ARTERIOSCLEROTIC CORONARY A. DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH CIRCA 15-18 Hours -INDEFINITE							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) PULMONARY EDEMA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/1, 1969 , to 3/2, 1969 , that (I) (we) lost the deceased alive on 3/2 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lawrence D. Marcus, M.D.				22c. DATE SIGNED 3/2/69		22d. PHYSICIAN'S NAME (Type) Lawrence D. Marcus	
22e. ADDRESS 1111 Spring Street, Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-5-1969		23c. NAME OF CEMETERY OR CREMATORY Culpeper National Cemetery		23d. LOCATION (City or Town) (County) (State) Prince William Co. Va.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5100 Wisc. Ave. N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR MAR 10 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

04160



[Faint, mostly illegible text and markings are visible throughout the page, including what appears to be a large, faint '2' in the center-right area.]

BOOK 11111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers (page 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04167

CERTIFICATE OF DEATH

04159

1. DECEASED-NAME (Type or print) First MABEL Middle M. Last MAYER			2a. DATE OF DEATH March Month 30 Day 1969 Year		2b. HOUR 3:30 P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH April 5, 1878		6. AGE (In years last birthday) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8702 Sundale Dr.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET AND NUMBER 8702 Sundale Drive	
14. FATHER'S NAME First Henry Middle Hassel Last		15. MOTHER'S MAIDEN NAME First Mary Middle Reilly Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578-48-5340 D	17. INFORMANT Address Mrs. Helen Townsend Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Visceral Failure 4409 DUE TO, OR AS-A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Senility					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Partial Intestinal Obstruction					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1960, to Mar 30, 1969, that (I) (we) last saw the deceased alive on Mar 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Francis T. Sharpe M.D. DEGREE				22c. DATE SIGNED May 30, 1969	
22d. PHYSICIAN'S NAME (Type) Francis T. Sharpe				22e. ADDRESS 4105 Wisconsin Ave Wash D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-2-69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
24. FUNERAL DIRECTOR Francis J. Collins		ADDRESS 500 University Blvd. W. Silver Spring, Md.		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
25a. REC'D BY REGISTRAR APR 3 1969				25b. REGISTRAR'S SIGNATURE Charles Judge	

04100

RECEIVED

04100



04100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04168

CERTIFICATE OF DEATH

04160

1. DECEASED-NAME (Type or print) <u>KATHRYN V. McCulloh</u>		First <u>KATHRYN</u> Middle <u>V.</u> Last <u>McCulloh</u>		2a. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1969</u>		2b. HOUR <u>6:15 P.M.</u>			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>Apr 3, 1891</u>		6. AGE (In years last birthday) <u>77</u> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery Co.</u> Md.			
10. CITY OR TOWN OF DEATH <u>Rockville</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Potomac Valley Nursing Home, Investments</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE <u>Alabama</u>		13b. COUNTY <u>Birmingham</u>		13c. CITY OR TOWN <u>Birmingham</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>2845 Thornhill Rd. S.</u>	
14. FATHER'S NAME <u>George W. McCulloh</u>		First <u>George</u> Middle <u>W.</u> Last <u>McCulloh</u>		15. MOTHER'S MAIDEN NAME <u>Linnie Burkey bile</u>		First <u>Linnie</u> Middle <u>Burkey</u> Last <u>bile</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. <u>423-60-1703</u>		17. INFORMANT <u>U. L. Beale (nephew)</u>		Address <u>222 Forest Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE C.V.A.</u> <u>4369</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HR.</u> <u>YEARS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>P.S.H.T. & C.H.F.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>MAR 28</u> , 19 <u>69</u> , to <u>MAR 29</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>MAR 28</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert C. Daddario</u>		22c. DATE SIGNED <u>3/29/69</u>		22d. PHYSICIAN'S NAME (Type) <u>ROBERT C. DADDARIO</u>		22e. ADDRESS <u>3413 CEDAR LANE BETHSDA</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3-31-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FROSTBURG MEMORIAL FROSTBURG, ALLEG, MD.</u>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <u>Joseph R. Rust, Frostburg</u>		ADDRESS <u>Frostburg</u>		25a. REC'D BY REGISTRAR <u>APR 3 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

28138

ALL 3 lots

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

04169

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04161

1. DECEASED-NAME (Type or print) First Middle Last Ruth NMN McKeehen			2a. DATE OF DEATH Month Day Year March 5, 1969		2b. HOUR P. 11:55
3. SEX Female	4. RACE White	5. DATE OF BIRTH August 9, 1985		6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Kansas	7b. CITIZEN OF WHAT COUNTRY? America	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
1d. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington D.C. D.C.		13c. CITY OR TOWN Washington D.C.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3244 38th Street NW	
14. FATHER'S NAME First Middle Last Thomas Stout		15. MOTHER'S MAIDEN NAME First Middle Last Lava nis Yoakum			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 240-30-5617		17. INFORMANT Patient's chart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GEN. ATHEROSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AGING PROCESS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES HOURS YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>DIABETES, CORONARY DISCRETE</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-12, 1969</u> , to <u>3-5, 1969</u> , that (I) (we) last saw the deceased alive on <u>3-5, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John L. Ford M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 3/6/69	
22d. PHYSICIAN'S NAME (Type) JOHN L. FORD				22e. ADDRESS 831 UNIVERSITY BLVD E. SILVER SPRING MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE March 8, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	
23d. LOCATION (City or Town) (County) (State) Colman Manor Pk. Md.		23e. REC'D BY REGISTRAR MAR 10 1969		23f. REGISTRAR'S SIGNATURE Charles Judge	

15110

RECEIVED BY FAX

04100

MAR 10 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

MARYLAND STATE DEPARTMENT OF HEALTH																																		
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																																		
04170					CERTIFICATE OF DEATH					04162																								
1. DECEASED-NAME (Type or print) <i>William J. McKEEVER</i>					2a. DATE OF DEATH Month <i>3</i> Day <i>23</i> Year <i>69</i>					2b. HOUR <i>8:35 PM</i>																								
3. SEX <i>Male</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>10-24-84</i>			6. AGE (In years last birthday) <i>84</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN																				
7a. BIRTHPLACE (State or foreign country) <i>New York</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>																									
10. CITY OR TOWN OF DEATH <i>Bethesda</i>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>					12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>					13b. COUNTY <i>Montgomery</i>					13c. CITY OR TOWN <i>Gaithersburg</i>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <i>14025 Millschoice Rd.</i>														
14. FATHER'S NAME First <i>Charles</i> Middle <i>McKee</i> Last <i>McKee</i>					15. MOTHER'S MAIDEN NAME First <i>McKee</i> Middle <i>McKee</i> Last <i>McKee</i>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>										16b. SOCIAL SECURITY NO. <i>4109</i>					17. INFORMANT <i>Hospital Records</i>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis & Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASIA</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Small Bowel Obstruction</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>1 hr</i> <i>4 years</i>																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																		
22b. SIGNATURE <i>Ira Mills</i>										22c. DATE SIGNED					22d. PHYSICIAN'S NAME (Type) <i>Ira Mills</i>					22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>					23b. DATE <i>3-26-69</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>					23d. LOCATION (City or Town) (County) (State) <i>Bladensburg Md.</i>																			
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>										25a. REC'D BY REGISTRAR <i>Charles Judge</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					25c. DATE <i>MAR 26 1969</i>														

05170

CERTIFICATE OF DEATH

05170

Name of Deceased		John Doe	
Age		45	
Sex		Male	
Race		White	
Date of Death		1945	
Place of Death		New York City	
Cause of Death		Heart Disease	
Occupation		Teacher	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOW 12:21 PM
Sophie Ann McMichael						March 11 1969			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		26 April 1923			45 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
New Jersey		USA					Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			The Clinical Center, NIH			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
New Jersey				V		Denville		YES	156 Florence Avenue
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Joseph Bolcar			Anna Bednar						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 144-14-0464		17. INFORMANT Bethesda, Maryland 20214 The Medical Records, The Clinical Center,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia and Encephalomalacia</u> 7464 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congenital Atrial Septal Defect</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Bronchopneumonia, Azotemia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Days 45 Years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
28 Feb. 69		Atrial Septal Defect			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I (this hospital) attended the deceased from 23 February 1969, to 11 March, 1969, that I (we) last saw the deceased alive on 11 March 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edward Jacobs, M.D.					22c. DATE SIGNED 11 March 1969			22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		March 15, 69		Gate of Heaven Cemetery		East Hanover N.J.			
24. FUNERAL DIRECTOR Loring Byers Chapel 8728 Liberty Rd. 21133					25a. REC'D BY REGISTRAR MAR 13 1969		25b. REGISTRAR'S SIGNATURE J. Charles Under		

2003, 6, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844,

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[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15		1		04172		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04164	
1. DECEASED-NAME (Type or print) First Middle Last						2a. DATE OF DEATH Month Day Year				2b. HOUR	
HUGO NMN MELLA						MARCH 30, 1969				9:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
MALE		CAUC		26 FEB., 1888		81 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Md.					
INDIANA		USA				MONTGOMERY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
BETHESDA		NAVAL HOSPITAL, BETHESDA		U. S. ARMY-RETIRED		PHYSICIAN					
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
VIRGINIA		ARLINGTON		ARLINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		333 GLEBE RD.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
GUSTAVE MELLA				LOUISE GUGGENHEIM							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
YES		2296011437		Gordon w. mella		805 BRICE RD. ROCKVILLE, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTS - SECONDARY TO MURAL THROMBI											
4109 DUE TO, OR AS A CONSEQUENCE OF LEFT VENTRICLE											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from 30 MARCH, 19 69, to 30 MARCH, 19 69, that (X) (we) last saw the deceased alive on 30 MARCH 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		Charles S. Crummy MD				22c. DATE SIGNED		31 MARCH 1969			
22d. PHYSICIAN'S NAME (Type)		CHARLES S. CRUMMY MD				22e. ADDRESS		NAVAL HOSPITAL, BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)		23e. REGISTRAR'S SIGNATURE			
CREMATION		4-1-1969		CEDAR HILL CREM.		SUITLAND, MD.		Charles Judge			
24. FUNERAL DIRECTOR		WASHINGTON, D.C.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JOSEPH GAWLER AND SONS FUNERAL HOME		WISCONSIN		DATE		APR 7 1969					

05120

9-27 11:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04173 CERTIFICATE OF DEATH 04165											
1. DECEASED-NAME (Type or print) Mary			First Helen			Middle Melvin			Last		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 26 October 1935			2a. DATE OF DEATH Month March Day 2 Year 1969		
7a. BIRTHPLACE (State or foreign country) Florida			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			6. AGE (In years last birthday) 33 YRS.		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			9. COUNTY OF DEATH Montgomery Md.		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Chevy Chase			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME James L. McCord			15. MOTHER'S MAIDEN NAME Ruth Clary			13e. STREET AND NUMBER 7617 Lynn Drive			12b. KIND OF BUSINESS OR INDUSTRY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No			16b. SOCIAL SECURITY NO. 262-54-0452			17. INFORMANT The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Right Lung (Widespread metastases) 1 1/2 yrs DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) 6 weeks											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 17 Feb. , 19 69 , to 2 March , 19 69 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 2 March , 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.											
22b. SIGNATURE Michael B. Mosher, MD						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 3 March 1969		
22d. PHYSICIAN'S NAME (Type) Michael B. Mosher, MD						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3-6-69			23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City or Town) (County) (State) Arlington Virginia		
24. FUNERAL DIRECTOR Robert A Pumphrey			ADDRESS 7557 Wisconsin Ave			25a. REG'D BY REGISTRAR 5 MAR 5 1969			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		
			Bethesda, Maryland								

TO THE HONORABLE THE ATTORNEY GENERAL
STATE OF MARYLAND
BALTIMORE

FROM THE HONORABLE THE ATTORNEY GENERAL
STATE OF MARYLAND
BALTIMORE

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the State of Maryland, this [illegible] day of [illegible], 19[illegible].

ATTEST: [Illegible]

NOTARY PUBLIC FOR MARYLAND

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04174 CERTIFICATE OF DEATH 04166									
1. DECEASED-NAME (Type or print) CHRISTOPHER			First Patrick Middle METREY Last			2a. DATE OF DEATH Month 3 Day 17 Year 69		2b. HOUR 5:10 A M	
3. SEX male		4. RACE white		5. DATE OF BIRTH 3/16/69		6. AGE (In years last birthday) — YRS.		IF UNDER 1 YEAR MONTHS — DAYS — HOURS 17 MIN	
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md		13b. COUNTY mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12004 Old Bridge Rd.	
14. FATHER'S NAME Richard First EVANS Middle Metrey Last 7			15. MOTHER'S MAIDEN NAME Mary First Sue Middle Sonefeld Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO.			17. INFORMANT Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress Syndrome 776.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 3-16-69 , 19 69 , to 3-17-69 , 19 69 , that (I) (we) lost saw the deceased alive on 3-17-69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert Scanlon M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 3/17/69				
22d. PHYSICIAN'S NAME (Type) Robert Scanlon M.D.					22e. ADDRESS 5406 Conn. Ave. NW. Wash. D.C.				
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 3/20/69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery			23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.		
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 Rock. Pike Rockville, Md.					25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 1-68
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04175									
04167									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
DINA			Miller			3 25 69			12 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		5-27-06		62 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Del.		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			Holy Cross Hospital			Retired, Government			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
md			montgomery		Silver Spring		YES		714 Silver Spring
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME: First Middle Last						
ARTHUR W. MILLER			Mary Gertrude Eagle						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
			215-44-3479		Dr. Donald Miller		7911 Ganssory Rd, Silver Spring		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Pulmonary failure									
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Carcinomatosis									
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Rt. breast									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (1) (this hospital) attended the deceased from June 1968, to March 24, 1969, that (1) (we) last saw the deceased alive on March 24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
James R. Coleman MD					March 25, 1969				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
JAMES R. COLEMAN MD.					9241 COLUMBIA BLVD MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
March 28-1969		March 28-1969		Cedar Hill Cemetery		B. Res. Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Arthur Walters					APR 1 1969		J. Charles Jones		

0413

STATE OF TEXAS
COUNTY OF DALLAS

IN SENATE,
January 1, 1904.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE,
MAY 1, 1903.
BY
J. W. WALKER,
COMMISSIONER.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A
45M

04176		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04168	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last P HEZEKIAH MILLS			2a. DATE OF DEATH MARCH Month 14 Day 69 Year			2b. HOUR 9:40pm	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH OCT 31, 1884		6. AGE (In years last birthday) 84 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) POTOMAC VALLEY NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 13768 TRAVILAH RD		14. FATHER'S NAME First Middle Last Charles R. Mills		15. MOTHER'S MAIDEN NAME First Middle Last Mary			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 217-09-8381A		17. INFORMANT Hazel G. Peters- 5401 Wehaken Rd. Wash. 16		Address D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Cardiac Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Age & Diabetes Mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few minutes 20 yrs 10 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Oct 5, 1959, to 14 Nov. 1969, that (I) (we) last saw the deceased alive on 10 Nov. 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William S. Murphy		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 14 Nov 1969	
22d. PHYSICIAN'S NAME (Type) William S. Murphy		22e. ADDRESS 615 W. Montgomery Ave., Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/18/69		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City or Town) (County) (State) Gaithersburg, Montg. Md.	
24. FUNERAL DIRECTOR Tyson Wheeler		1331 Rockville Pike, Rockville, Maryland MAR 21 1969 25b. REGISTRAR'S SIGNATURE James J. Jones					

DATE

WHITE
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MONTGOMERY

1870 TENNESSEE
MONTGOMERY
ROCKWELL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04177									
04169									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last DORIS MARGUERITE MILNE					2a. DATE OF DEATH Month Day Year 3 12 69			2b. HOUR 7:40 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 9-9-1909		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS 6 5	
7a. BIRTHPLACE (State or foreign country) MICH		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN. & HOSP			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY MONT		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER SILVER SPRING 1405 LEISTER DRIVE	
14. FATHER'S NAME First Middle Last CORTIS Ford			15. MOTHER'S MAIDEN NAME First Middle Last STELLA GREEN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 579-60-4801		17. INFORMANT J. Scott Milne, Jr. Address GROSS 12700 Chilton Circle, Sil. Spr. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 ASYSTOLE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONDUCTION DEFECT DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROSIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 min ?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Jan 1966, to May 1969, that (I) (we) last saw the deceased alive on March 12 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harold M. Swartz, MD					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED March 13, 1969		
22d. PHYSICIAN'S NAME (Type) Harold M. Swartz					22e. ADDRESS 1407 NORTHCREST DR.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE March 15, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. Silver Spring, Md.					25. REC'D BY REGISTRAR MAR 19 1969		25b. REGISTRAR'S SIGNATURE		

00125

OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK

IN SENATE

04137

1908

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
FOR THE YEAR 1908

LAND OFFICE

NEW YORK

1909

THE STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY

PRINTED BY THE STATE PRINTING OFFICE
ALBANY, N. Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 1-68

04178		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04170	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR	
Lawrence Gustav Mohr				March Month 1 Day 1969 Year		9:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Male		White		30 October 1909		59 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Georgia		USA				Montgomery Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		The Clinical Center, NIH		Administrator		US Government	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Montgomery		Potomac		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.	
First Middle Last		First Middle Last		Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give year or dates of service)		084-09-7042	
Gustav L. Mohr		Selma Auerbach					
17a. INFORMANT		17b. ADDRESS		17c. PHONE NO.		17d. RELATIONSHIP	
Bethesda, Maryland		The Medical Records, The Clinical Center,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20. MEDICAL CERTIFICATION		21. SIGNATURE	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myelogenous Leukemia</u> <u>2051</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thrombocytopenia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		7 Years 1 Month					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>17 February, 1969</u> , to <u>1 March, 1969</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>1 March</u> 19 <u>69</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Ervin H. Epstein, Jr., M.D.</u> DEGREE 22c. DATE SIGNED <u>3 March 1969</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		3-5-1969		Potomac Methodist Church		Potomac, Montgomery County, Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc., 3150 Wisc. Ave. N.W., Wash., D.C., 20016		DATE <u>MAR 10 1969</u>		<u>Charles Judge</u>			

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]

RE: [Illegible]
[Illegible]

On 11/10/60, [Illegible] advised that [Illegible]
[Illegible]

[Illegible] advised that [Illegible]
[Illegible]

[Illegible] advised that [Illegible]
[Illegible]

[Illegible] advised that [Illegible]
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[Illegible] advised that [Illegible]
[Illegible]

[Illegible] advised that [Illegible]
[Illegible]

[Illegible] advised that [Illegible]
[Illegible]

[Illegible] advised that [Illegible]
[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 04179 CERTIFICATE OF DEATH 04171 </div>									
1. DECEASED-NAME (Type or print)			First (Lynch) Middle M. Last MOORE			2a. DATE OF DEATH Month Day Year Mar. 28, 1969		2b. HOUR 10 A. M.	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH June 19, 1889		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7103 Clarendon Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7103 Clarendon Road	
14. FATHER'S NAME First Middle Last Edward Lynch				15. MOTHER'S MAIDEN NAME First Middle Last Mary Nolan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 25-121-126		16c. INFORMANT Daughter Mrs. Mary Wilkinson 5603 S. Lamar Rd., N.W. Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROSIS, GENERAL</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yr.
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 1966, to _____, 1969, that (I) (we) lost the deceased on _____, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Leo M. Curtis		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-28-69			
22d. PHYSICIAN'S NAME (Type) LEO M. CURTIS		22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-31-69		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		23d. LOCATION (City or Town) (County) (State) West Roxbury, Mass.			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. BY REGISTRAR DATE APR 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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04180		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04172	
Item 13 Film 410 3/14/69 kk							
1. DECEASED-NAME (Type or print) First Middle Last MILWARD F. MOORE				2a. DATE OF DEATH Month Day Year MARCH 4 69		2b. HOUR 12:30 AM	
3. SEX M		4. RACE W		5. DATE OF BIRTH 3-14-84		6. AGE (In years lost birthday) 84 YRS.	
7a. BIRTHPLACE (State or foreign country) Ky		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HONY CROSS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Clerk		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE No		13b. COUNTY MONTGOMERY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER MONTGOMERY / NURSING HOME	
14. FATHER'S NAME First Middle Last George Moore		15. MOTHER'S MAIDEN NAME First Middle Last Sus. D. Moore					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 404-14-9685		17. INFORMANT Hosp Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-2</u> , 19 <u>69</u> , to <u>3-4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert Kramer M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/4/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 8984 16th Street Silver Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/6/69		23c. NAME OF CEMETERY OR CREMATORY Monacacy		23d. LOCATION (City or Town) (County) (State) Beallsville Montg. Md	
24. FUNERAL DIRECTOR Hillon Funeral Home Barnevillie Md				25a. REC'D BY REGISTRAR MAR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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RECEIVED OF DEAN

for payment of

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last GRACE BESSIE MORRIS			2a. DATE OF DEATH Month Day Year 3 4 1969		2b. HOUR 5:15 P.M.	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 5/14/1880		6. AGE (In years lost birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Univ. Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Maid		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Wash., DC		13b. COUNTY DC		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 730 Quebec Pl., NW, Wash., DC	
14. FATHER'S NAME First Middle Last ? Brown ?			15. MOTHER'S MAIDEN NAME First Middle Last Jane ? ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578-44-4277		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Arteriosclerosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerosis Heart Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> , 19 <u>68</u> , to <u>3/4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L. Cannaday</u>				22c. DATE-SIGNED 3/4/69					
22d. PHYSICIAN'S NAME (Type) Dr. L. Cannaday/Dibble				22e. ADDRESS 3632 Georgia Ave., NW, Wash., DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-8-69		23c. NAME OF CEMETERY OR CREMATORY HARMONY MENT. PK.		23d. LOCATION (City or Town) (County) (State) LANDOVER PR. GEO. MD.			
24. FUNERAL DIRECTOR BETAYLOR 904 GUYTON, W. D.C.				25a. REC'D BY REGISTRAR DATE MAR 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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1915. 1916. 1917. 1918. 1919. 1920. 1921. 1922. 1923. 1924. 1925. 1926. 1927. 1928. 1929. 1930. 1931. 1932. 1933. 1934. 1935. 1936. 1937. 1938. 1939. 1940. 1941. 1942. 1943. 1944. 1945. 1946. 1947. 1948. 1949. 1950. 1951. 1952. 1953. 1954. 1955. 1956. 1957. 1958. 1959. 1960. 1961. 1962. 1963. 1964. 1965. 1966. 1967. 1968. 1969. 1970. 1971. 1972. 1973. 1974. 1975. 1976. 1977. 1978. 1979. 1980. 1981. 1982. 1983. 1984. 1985. 1986. 1987. 1988. 1989. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232. 2233. 2234. 2235. 2236. 2237. 2238. 2239. 2240. 2241. 2242. 2243. 2244. 2245. 2246. 2247. 2248. 2249. 2250. 2251. 2252. 2253. 2254. 2255. 2256. 2257. 2258. 2259. 2260. 2261. 2262. 2263. 2264. 2265. 2266. 2267. 2268. 2269. 2270. 2271. 2272. 2273. 2274. 2275. 2276. 2277. 2278. 2279. 2280. 2281. 2282. 2283. 2284. 2285. 2286. 2287. 2288. 2289. 2290. 2291. 2292. 2293. 2294. 2295. 2296. 2297. 2298. 2299. 2300. 2301. 2302. 2303. 2304. 2305. 2306. 2307. 2308. 2309. 2310. 2311. 2312. 2313. 2314. 2315. 2316. 2317. 2318. 2319. 2320. 2321. 2322. 2323. 2324. 2325. 2326. 2327. 2328. 2329. 2330. 2331. 2332. 2333. 2334. 2335. 2336. 2337. 2338. 2339. 2340. 2341. 2342. 2343. 2344. 2345. 2346. 2347. 2348. 2349. 2350. 2351. 2352. 2353. 2354. 2355. 2356. 2357. 2358. 2359. 2360. 2361. 2362. 2363. 2364. 2365. 2366. 2367. 2368. 2369. 2370. 2371. 2372. 2373. 2374. 2375. 2376. 2377. 2378. 2379. 2380. 2381. 2382. 2383. 2384. 2385. 2386. 2387. 2388. 2389. 2390. 2391. 2392. 2393. 2394. 2395. 2396. 2397. 2398. 2399. 2400. 2401. 2402. 2403. 2404. 2405. 2406. 2407. 2408. 2409. 2410. 2411. 2412. 2413. 2414. 2415. 2416. 2417. 2418. 2419. 2420. 2421. 2422. 2423. 2424. 2425. 2426. 2427. 2428. 2429. 2430. 2431. 2432. 2433. 2434. 2435. 2436. 2437. 2438. 2439. 2440. 2441. 2442. 2443. 2444. 2445. 2446. 2447. 2448. 2449. 2450. 2451. 2452. 2453. 2454. 2455. 2456. 2457. 2458. 2459. 2460. 2461. 2462. 2463. 2464. 2465. 2466. 2467. 2468. 2469. 2470. 2471. 2472. 2473. 2474. 2475. 2476. 2477. 2478. 2479. 2480. 2481. 2482. 2483. 2484. 2485. 2486. 2487. 2488. 2489. 2490. 2491. 2492. 2493. 2494. 2495. 2496. 2497. 2498. 2499. 2500. 2501. 2502. 2503. 2504. 2505. 2506. 2507. 2508. 2509. 2510. 2511. 2512. 2513. 2514. 2515. 2516. 2517. 2518. 2519. 2520. 2521. 2522. 2523. 2524. 2525. 2526. 2527. 2528. 2529. 2530. 2531. 2532. 2533. 2534. 2535. 2536. 2537. 2538. 2539. 2540. 2541. 2542. 2543. 2544. 2545. 2546. 2547. 2548. 2549. 2550. 2551. 2552. 2553. 2554. 2555. 2556. 2557. 2558. 2559. 2560. 2561. 2562. 2563. 2564. 2565. 2566. 2567. 2568. 2569. 2570. 2571. 2572. 2573. 2574. 2575. 2576. 2577. 2578. 2579. 2580. 2581. 2582. 2583. 2584. 2585. 2586. 2587. 2588. 2589. 2590. 2591. 2592. 2593. 2594. 2595. 2596. 25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|--|--|--|---|--|---|---------------------|
| 04182 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04174 | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Joseph H. Murdock | | | | 2a. DATE OF DEATH
Month Day Year
3-15-69 | | | 2b. HOUR
3:30 PM |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
9-16-29 | | 6. AGE (In years last birthday)
74 YRS. | |
| 7a. BIRTHPLACE (State, or foreign country)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Suburban | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 13a. USUAL RESIDENCE (Where deceased lived, if in institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Sp. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First Middle Last
David B. Murdock | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Annie E. Williams | | 13e. STREET AND NUMBER
9915 Indian Lane | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Joseph B. Murdock 9915 Indian Lane SS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION - RECENT - REMOTE 4109
DUE TO, OR AS A CONSEQUENCE OF
(b) CORONARY ARTERIOSCLEROSIS & THROMBOSIS
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Ruptured abdominal aortic aneurysm | | | | | | | |
| 19a. DATE OF OPERATION
2/14/69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
aortic aneurysm | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/14, 1969, to 3/15, 1969, that (I) (we) lost saw the deceased alive on 3/15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Joseph F. Schanno MD | | | | 22c. DATE SIGNED
16 Mar 69 | | 22d. PHYSICIAN'S NAME (Type)
Joseph F. Schanno | |
| 22e. ADDRESS
8218 Phoenician Ave. Beth Md | | | | 22f. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
March 18, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, 8434 Georgia Avenue Silver Spring, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE MAR 20 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

38140

2000

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|-------------------------------|--|
| 04183 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04175 | | | |
| Item 6 Film 410 3/12/69 kk | | | | CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Blanche R Murphy | | | | 2a. DATE OF DEATH Month Day Year
March 3 1969 | | | | 2b. HOUR
11:50 PM | | | |
| 3. SEX
Female | | 4. RACE
N | | 5. DATE OF BIRTH
1-19-31 | | 6. AGE (In years last birthday)
38 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Tenn. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton, Md | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
University Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
cab driver | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Washington, DC | | 13b. COUNTY
DC | | 13c. CITY OR TOWN
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
237 Mississippi Ave SE | | | |
| 14. FATHER'S NAME First Middle Last
Milton Murphy | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Cedessa Dailey | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)
No | | | | 16b. SOCIAL SECURITY NO.
678447111 | | 17. INFORMANT Address
Mary Tibbs 1701 16th St NW Wash DC | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u>
180x DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>uterine (cervical) carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>unknown</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/26</u> , 19 <u>68</u> , to <u>Mar 4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Mar 1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Henry G. Hadley</u> | | DEGREE
M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
2-4-69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Henry G. Hadley, M.D. | | 22e. ADDRESS
4601 Nichols Avenue, S. W | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/7/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Mem Cem | | 23d. LOCATION (City or Town) (County) (State)
Highland Park, Md. | | | | | |
| 24. FUNERAL DIRECTOR
Petworth Funeral Home | | ADDRESS
814 Upshur St. N/W | | 25a. REC'D BY REGISTRAR
DATE MAR 7 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04184

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04176

| | | | | | | | | | | | | | | | | | |
|---|--|------------------|-------------------|---|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) <i>Raymond B Murray Jr.</i> | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year <i>Mar. 7 1969</i> | | | | 2b. HOUR <i>10:30</i> - M | | | | | | | |
| 3. SEX <i>M</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH <i>Dec. 9, 1908</i> | | 6. AGE (In years last birthday) <i>50</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD Month Day Year <i>Mar. 7 1969</i> | | 2d. HOUR <i>10:50</i> M | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Conn.</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Seidman</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>U.S.A. Research</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Montgomery</i> | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | | | 13b. COUNTY <i>Mont.</i> | | | | 13c. CITY OR TOWN <i>Springton</i> | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>5011 Euclid Ave.</i> | | | |
| 14. FATHER'S NAME First Middle Last <i>Raymond B Murray</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Helen Zimmerman</i> | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i> | | | | 16b. SOCIAL SECURITY NO. <i>577-12-0028</i> | | | | 17. INFORMANT ADDRESS <i>Same as above</i> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute.</i>
<i>4119</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | | | EXAMINER'S NAME (Type) | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED <i>Mar 7, 1969</i> | | | | | |
| ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | | | 23b. DATE <i>3-11-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN CEMETERY</i> | | | | 23d. LOCATION (City or Town) (County) (State) <i>SILVER SPRING, MARYLAND</i> | | | | | | | |
| 24. FUNERAL DIRECTOR <i>Francis J. Collins 500 Univ. Blvd. W.</i> | | | | 25a. REGD BY REGISTRAR <i>MAR 12 1969</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | | |

AMERICAN EXAMINERS' REPORT OF RESULTS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) MABEL | | | First S. | | | Middle NASH | | | 2a. DATE OF DEATH
Month 03 Day 19 Year 69 | | | 2b. HOUR
2 PM | |
| 3. SEX
FEMALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
SEPT. 23, 1888 | | | 6. AGE (In years
last birthday) 80 YRS. | | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 |
| 7a. BIRTHPLACE (State or foreign
country) NEW YORK | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY COUNTY Md. | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) CHEY CHASE NURSING HOME | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) AT HOME | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE WASH. D.C. | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
3617 QUESADA ST. | |
| 14. FATHER'S NAME
First JAMES | | | Middle WHITE | | | Last ELIZABETH | | | 15. MOTHER'S MAIDEN NAME
First ELIZABETH | | | Middle CARROLL | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
578-44-1333 | | | 17. INFORMANT
JAMES NASH, SON, SAME AS ITEM #13 | | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pneumonia | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration & Atelectasis, Chronic Bronchitis 2 months | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral arteriosclerosis & Senile Psychosis 5 years | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1955 , 19____, to March 19, 1969 , that (I) (we) last
saw the deceased alive on 3/9 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Paul F. Jaquet, M.D. | | | DEGREE | | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
3/19/69 | | | | |
| 22d. PHYSICIAN'S
NAME (Type) Paul F. Jaquet, M.D. | | | 22e. ADDRESS
3701 MASS. Ave. N.W. Wash D.C. | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
3-21-1969 | | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Silver Spring, Montgomery Co. Md. | | | | |
| 24. FUNERAL DIRECTOR
Josaph Gawler's Sons, Inc., 5130 Wisc. Ave. | | | ADDRESS
N.W., Wash., D.C., 20016 | | | 25a. REC'D BY REGISTRAR
DATE MAR 26 1969 | | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | | | | |

04182

EXHIBIT OF

Handwritten notes, possibly a list or description, written in cursive.

Handwritten word or phrase.

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Handwritten text, possibly a date or reference number.

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Handwritten text, possibly a date or reference number.

Handwritten signature or name.

Handwritten text, possibly a name or title.

Handwritten text, possibly a date or reference number.

Printed text at the bottom of the page, including a date range (1963-1965) and a company name (General Electric).

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| Item 13 See birth cert. and Maryland State Department of Health | | | | | | | | | |
|--|--|--|--|--|-------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04186 | | | | | 04178 | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | 2a. DATE OF DEATH | | | | |
| First Middle Last | | | | | Month Day Year 2b. HOUR | | | | |
| Nauale | | | | | 3 27 69 545 M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 4 HRS. HOURS MIN. | |
| Female | | Caucasian | | 3-27-69 | | — YRS. | | 4 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Maryland | | USA | | | | Montgomery | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | Holy Cross | | None | | None | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | P.G. Rockville | | Rockville | | | | 5017 Naples Avenue | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| First Middle Last | | First Middle Last | | NA NA NA | | NA | | Address | |
| William W. Nauale | | Charlene | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Immaturity | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| NA | | NA | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | 19 | | NA | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | N.A. | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/27/69 11:55 P.M. to 3/27/69 5:45 P.M., that (I) (we) last saw the deceased alive on 3/27/69 5:45 P.M., and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| Richard J. Hollander | | 3/28/69 | | Richard J. Hollander | | 1110 Spring Street, Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 4/1/69 | | Gate of Heaven | | Silver Spring, Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. DATE | | | |
| Tyson Wheeler Funeral Home 1331 Rock. Pike Rockville, Maryland | | APR 7 1969 | | Charles Judge | | | | | |

1188

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|---|---|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> 04187 04179 </div> <div style="display: flex; justify-content: space-between;"> Item 13 Film 411 4/2/69 kk CERTIFICATE OF DEATH </div> | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) ROSE NELSON | | | | | 2a. DATE OF DEATH
March 20 1969 | | | 2b. HOUR
12¹³ P.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
May 10, 1882 | | 6. AGE (In years last birthday)
86 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Unknown | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Germantown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Marylander Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Germantown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
Unknown | | | 15. MOTHER'S MAIDEN NAME
Unknown | | | 13e. STREET AND NUMBER
Arden Road R.F.D. Germantown, Md. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
577-30-3835 | | 17. INFORMANT
Marylander Nursing Home-Germantown, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4109 IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 minutes
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1963 to 20 March 1969 , that (I) was lost saw the deceased alive on 20 March 1969 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) do (did) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Gordon Murdoch Smith, MD DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
20 March 69 | | |
| 22d. PHYSICIAN'S NAME (Type)
Gordon Murdoch Smith, MD | | | | | 22e. ADDRESS
Barnesville, Md 20703 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/25/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Glenwood | | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md. | | | | | 25a. REC'D BY REGISTRAR
MAR 26 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

73140

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 11-89

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|--|--|---|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 04188 | | | | | | | | | |
| 04180 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First <u>Elizabeth</u> Middle <u>Bennett</u> Last <u>Nettleship</u> | | | a. DATE OF DEATH | | 2b. HOUR | |
| <u>Elizabeth Bennett Nettleship</u> | | | | | | Month <u>MAR.</u> Day <u>8</u> Year <u>1969</u> | | <u>2:10 A</u> | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| <u>Female</u> | | <u>White</u> | | <u>10-11-1890</u> | | <u>78</u> | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | |
| <u>MASH.D.C.</u> | | <u>U.S.A.</u> | | | | <u>Montgomery</u> | | <u>BETHESDA</u> | |
| 11a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 11b. COUNTY | | 11c. CITY OR TOWN | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| <u>MARYLAND</u> | | <u>Montgomery</u> | | <u>Cherry Chase</u> | | <u>At Home</u> | | | |
| 13a. FATHER'S NAME First Middle Last | | 13b. MOTHER'S MAIDEN NAME First Middle Last | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER | | 13e. STREET AND NUMBER | |
| <u>William A. Bennett</u> | | <u>Martha</u> | | | | <u>5700 Dorset Ave.</u> | | | |
| 14a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 14b. SOCIAL SECURITY NO. | | 14c. INFORMANT | | Address | | | |
| <u>NO</u> | | <u>577-05-7130</u> | | <u>MRS. RICHARD E. CARPENTER, DAUGHTER,</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| <u>Arteriosclerotic Cerebrovascular Disease - Cerebral Thrombosis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> , 19 <u>69</u> , to <u>3/8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | 22e. DATE SIGNED | | 22f. REGISTRAR'S SIGNATURE | |
| <u>Richard H. Pollen</u> MD | | <u>RICHARD H. POLLEN</u> | | <u>10400 CONNECTICUT Ave, Kensington Md.</u> | | <u>3/8/69</u> | | <u>Charles Judge</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | 23e. REC'D BY REGISTRAR | |
| <u>Burial</u> | | <u>3-11-1969</u> | | <u>Parklawn Cemetery</u> | | <u>Rockville, Montgomery Co., Md.</u> | | <u>MAR 14 1969</u> | |
| 24. FUNERAL DIRECTOR | | 24a. NAME (Type) | | 24b. ADDRESS | | 24c. CITY OR TOWN | | 24d. STATE | |
| <u>Joseph Gawler's Sons, Inc.,</u> | | <u>5130 Wisc. Ave.</u> | | <u>N.W., Wash., D.C.,</u> | | <u>20016</u> | | | |

04182

Hockelheim

Bennett

Elizabeth

Barial 2-11-1969
Joseph David's Sons, Inc., 130 Mac. Ave.
A.S. Smith, P.O. Box 2008

Hockelheim, Montgomery Co., Pa.

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|---|--|---|--|--|-----------------------------|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|
| 04189 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04181 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last SARAH ELIZABETH NORWOOD | | | | | | | | | | 2a. DATE OF DEATH Month Day Year MARCH 28, 1969 | | | | | | | | | | 2b. HOUR 6:25 P.M. | | | | | | | | | |
| 3. SEX FEMALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH 3-27-06 | | | 6. AGE (In years last birthday) 63 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? AMERICA | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH MONTGOMERY, Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. & HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY Carroll | | | 13c. CITY OR TOWN HT. AIRY | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 307 CARROLL AVENUE | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last EDWARD BOWMAN | | | 15. MOTHER'S MAIDEN NAME First Middle Last MARY JONES | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address HOSPITAL RECORDS, TAKOMA PARK, MD. | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 180X central motor stroke
DUE TO, OR AS A CONSEQUENCE OF (b) curricular carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug, 1969, to Sep, 1969, that (I) (we) last saw the deceased alive on 3/28/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Lewis William Danner | | | 22c. DATE SIGNED 5/26/69 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Lewis William Danner | | | 22e. ADDRESS 8906 Red Bull Rd. Silver Spring, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE April 1, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY Damascus Meth. | | | 23d. LOCATION (City or Town) (County) (State) Damascus, Md. | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE APR 3 1969 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | |



110011

110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04190

04182

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME
(Type or print) Loyal First LOYAL Middle IRVING Last NUTTING | | | 2a. DATE OF DEATH
Month 3 - Day 26 - Year 1969 | | | 2b. HOUR 3:30 P | | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
11-22-1901 | | 6. AGE (In years last birthday)
67 yrs WRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | Md. | | |
| 10. CITY OR TOWN OF DEATH
Olney | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Montgomery General Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Broker | | | 12b. KIND OF BUSINESS OR INDUSTRY
Stock | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Howard ✓ | | 13c. CITY OR TOWN
Columbia | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 10850 Green Mountain Circle, #211 | | |
| 14. FATHER'S NAME First J. Middle Cole Last Nutting | | | 15. MOTHER'S MAIDEN NAME First Mary Middle Cecelia Last Walsh | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
367-05-3520A | | 17. INFORMANT Address #13
Mrs. Ada Devlin Nutting, Widow, same as item | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic atherosclerotic ht. dis.
(b) 5 years
DUE TO, OR AS A CONSEQUENCE OF
(c) 5 years | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. 19 Month 1 Day 26 Year 1968
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. 3126 City or Town Olney County Howard State Md. | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 1, 1968 to 3/26/1969 , that (I) (we) lost the deceased alive on 3/26/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Christian S. Mass, MD | | | | | | 22c. DATE SIGNED 3/27/69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Christian S. Mass, MD | | | | | | 22e. ADDRESS #21 South St. Johns Lane, Ellicott City | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
3-29-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Montgomery Co. Md. | | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wis. Ave., N.W., Wash., D.C., 20016 | | | | | | 25a. REC'D BY REGISTRAR
APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE Charles J. Jones | | | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 04191 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04183 | |
| Item 8 Film 410 3/14/69 kk | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Almeda M Edwards O'Donnell | | | | 2a. DATE OF DEATH Month Day Year
March 10 1969 | | 2b. HOUR
7:15 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
4/10/89 | | 6. AGE (In years last birthday)
79 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Suburban Hosp | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE
N.Y. | | 13b. COUNTY
New York | | 13c. CITY OR TOWN
New York | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
45 Tudor City Place | | 14. FATHER'S NAME First Middle Last
Silas Carter Edwards | | 15. MOTHER'S MAIDEN NAME First Middle Last
Martha Louise Papin | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
DR. Daniel Blangkey | | Address
6411 Beardsdale Drive ChCh. Md | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | |
| PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a)
4122 Cerebral Vascular Accident | | DUE TO, OR AS A CONSEQUENCE OF (b)
EMBOLISM | | DUE TO, OR AS A CONSEQUENCE OF (c)
CARDIOVASCULAR RENAL DISEASE | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1b.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | 22a. I certify that (I) (this hospital) attended the deceased from 3/10, 1969, to 3/10, 1969, that (I) (we) last saw the deceased alive on 3/9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
| 22b. SIGNATURE
A. J. Brennan MD | | 22c. DATE SIGNED
3/10/69 | | 22d. PHYSICIAN'S NAME (Type)
A. J. Brennan | | 22e. ADDRESS
Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-13-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Wooster Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Danbury Conn. | |
| 24. FUNERAL DIRECTOR
Robert A. Cunningham | | ADDRESS
7537-26th Ave | | 25a. REC'D BY REGISTRAR
MAR 12 1969 | | 25b. REGISTRAR'S SIGNATURE | |

John ...
County ...
Woods of Cemetery ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper sheets 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 11-69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|---|--|------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) HELEN BRYAN OEHMANN | | | | | 2a. DATE OF DEATH
Month 3 Day 9 Year 69 | | 2b. HOUR 7:34 M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH July 30, 1918 | | 6. AGE (In years last birthday) 50 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10831 EASTWOOD AVE | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 10831 Eastwood Ave. | |
| 14. FATHER'S NAME First J. Middle S. Last Bryan | | | 15. MOTHER'S MAIDEN NAME First Helen Middle Broughton Last Broughton | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 578-14-9116 | | 17. INFORMANT John B. Oehmann Address 10831 Eastwood Silver Spring | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
3480
DUE TO, OR AS A CONSEQUENCE OF
(b) 3480
DUE TO, OR AS A CONSEQUENCE OF
(c) 3480
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 22, 1968 , to Mar 9, 1969 , that (I) (we) last saw the deceased alive on Mar 4, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Bernard A. Fitzgerald MD DEGREE MD | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 3-9-69 | | | |
| 22d. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD | | | | 22e. ADDRESS 47400 Blvd E, Silver Spring Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Mar. 12, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 23d. LOCATION (City or Town) Silver Spring, Md. (County) (State) | | | |
| 24. FUNERAL DIRECTOR Francis J. Collins, 500 University Blvd., West Silver Spring, Maryland ADDRESS | | | | 25a. REC'D BY REGISTRAR MAR 12 1969 DATE | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

SELAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1
45M - 11-89

| 04193 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04185 | | | | | |
|---|--|--|--|--|--|--|--|--|--|-------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Anna | | Bokrer | | O'Leary | | | | March 30, 1969 | | 3 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | 6-19-83 | | 85 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | Suburban Housewife | | Housewife | | Private | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | Montgomery | | Bethesda | | | | 7824 - Glenbrook Rd. | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| Charles | | Bokrer | | | | | | Annie R. Hodges | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| No | | 574-07-6891 | | Marie Peterson | | 1113 - Glenbrook Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 4109 | | | | Congestive Heart Failure | | | | 3 weeks | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | (b) Coronary Atherosclerotic Heart Disease | | | | 10 years | | | |
| | | | | (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 19 55, to Mar 30, 1969, that (I) (we) last saw the deceased alive on Mar 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | |
| Michel M. Healy MD | | 3/30/69 | | Michel M. HEALY, MD | | 5411 W. Cedar La, Bethesda Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 4/2/69 | | Rockville Cemetery | | Rockville, Montgomery Md. | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Tyson Wheeler Funeral Home Rockville, Md. | | DATE APR 7 1969 | | J Charles Judge | | | | | | | |

04193

TESTIFICATE OF DEATH

04193

[Faint, mostly illegible text and markings on a form, possibly containing a signature and various fields.]

APR 3 1969
[Faint text at the bottom of the page, including a date and possibly a name or title.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MC-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04186 | | |
|--|--|--|--|---|--|--|--|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) <u>Katherine A Parent</u> | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>March</u> Day <u>5</u> Year <u>1969</u> | | | | 2b. HOUR <u>12:30</u> M | | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH <u>2/14/07</u> | | 6. AGE (In years last birthday) <u>62</u> YRS. | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS
HOURS _____ MIN. _____ | | |
| 7a. BIRTHPLACE (State or foreign country) <u>Massachusetts</u> | | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <u>Montgomery</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH <u>Bethesda</u> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hosp</u> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Grant Advisor</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov. - NIH</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md</u> | | | | 13b. COUNTY <u>Mont</u> | | 13c. CITY OR TOWN <u>Bethesda</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>10509 Montrose Ave</u> | | |
| 14. FATHER'S NAME First <u>O.</u> Middle <u>N.</u> Last <u>Parent</u> | | | | | | 15. MOTHER'S MAIDEN NAME First <u>Grace</u> Middle <u>Gertrude</u> Last <u>Bussell</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16b. SOCIAL SECURITY NO. <u>162-10-4701</u> | | 17. INFORMANT <u>Mr. David E. Parent, 135 Chesnut St. Richmond Hgts. Ohio</u> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
<u>4109</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Coronary Arterio Sclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>24 hrs.</u>
<u>years</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Lobar Pneumonia, Left Lung</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION _____ | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____ | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) _____ | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) _____ | | | | 21f. LOCATION Street or R.F.D. No. _____ | | City or Town _____ | | County _____ State _____ | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <u>March 5, 1969</u> | | | |
| EXAMINER'S NAME (Type) <u>JOHN G. BALL, MD.</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| ADDRESS (Street, city, town, or county) <u>Montgomery Co. Md.</u> | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>3-8-69</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | | | | 23d. LOCATION (City or Town) (County) (State) <u>Rockville, Montg. Co. Md.</u> | | | | |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | | | | | 25a. REC'D BY REGISTRAR <u>MAR 12 1969</u> | | 25b. REGISTRAR'S SIGNATURE <u>William J. Jacobs</u> | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04187 | | | | |
|---|---------|------------------|--|---|------------------------------------|---|-------------------------------|--|--|--|----------|----------------------------------|--------|------|
| 04195 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | Middle | | Last | | 2a. DATE KNOWN OF ESTI-
MATED | | | 2b. HOUR | | |
| WILLIAM | | | V. A. | | Pastor | | Month 3 Day 3 Year 1969 | | | 7A M | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year | | 2d. HOUR | | | |
| Male | White | 12/17/-3 | | 65 66 YRS. | 2 16 | | | | 3 3 69 | | 7A M | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. | | | |
| Rumania | | | USA Canada | | | Montgomery | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Silver Spring Md. | | | Holy Cross Hospital | | | Security Guard - New Zealand Emb. | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| Maryland | | | Montgomery | | | Kensington | | | | 11528 Soward Dr. Kens Md. | | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Julius | | | Pastor | | | | | | Rose | | | Stanish | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| none | | | | | | none | | | wife Beatrice L | | | 11528 Soward Dr., Kensington Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>White Coronary Insufficiency</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4123</u>
(b) <u>Coronary Artery Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | Belden R. Reap | | | M.D. | | | 22b. DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | Belden R. Reap, M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | March 3, 1969 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | | March 6, 1969 | | Gate of Heaven Cemetery | | | Silver Spring, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR (Name and address) | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Warner E. Pumphrey, Inc. Silver Spring, Md. | | | | | | MAR 7 1969 | | Charles Judge | | | | | | |

79130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
45M - 1-69

| | | | | | | | | | |
|--|--|---|--|---|---|---|--|---|--|
| 04196 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04188 | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
EMILY R. PECK | | | | | | 2a. DATE OF DEATH Month Day Year
MARCH 18 1969 | | 2b. HOUR
12:30 P M | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
6/22/75 | | 6. AGE (In years last birthday)
93 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
WASH D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH
CHEVY CHASE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
BETHESDA-SILVER SPRING NURSING HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker - own home | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
8505 SPRINGVALE ROAD | |
| 14. FATHER'S NAME First Middle Last
Edward S. Peck | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Katherine Raymond | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
NO | | 16b. SOCIAL SECURITY NO.
579-60-1612 | | 17. INFORMANT
J1 PHILIP PECK | | Address 3411 TURNER LANE CHEVY CHASE, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4409 CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) ATHEROSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4-5 MONTHS
SEVERAL YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 19a. DATE OF OPERATION
12/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CATARACT | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/10, 1966, to 3/18, 1969, that (1) (we) last saw the deceased alive on 3/15/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James A. Roberts | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/18/69 | | |
| 22d. PHYSICIAN'S NAME (Type)
JAMES A. ROBERTS | | | | | 22e. ADDRESS
8907 GEORGIA AVE. SILVER SPRING MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
3-18-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 24 1969 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 yrs after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 04197 | | | | | | | | 04189 | | | |
| 1. DECEASED NAME
(Type or print) <i>Manuel</i> | | First | | Middle | | Last <i>Peon</i> | | 2a. DATE OF DEATH
<i>Mar</i> Month <i>18</i> Day Year <i>69</i> | | 2b. HOUR
<i>8:25</i> AM | |
| 3. SEX
<i>MALE</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>11/10/04</i> | | 6. AGE (In years last birthday)
<i>64</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Cuba</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | | | | Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Fairland Nursing Home</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Store owner</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>TAKOMA PARK</i> | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER
<i>506 Dummer Ave</i> | | | |
| 14. FATHER'S NAME
<i>Manuel A Peon</i> | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME
<i>LOUISA</i> | | First Middle Last
<i>Rubio</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>265-74-6077</i> | | 17. INFORMANT
<i>EMMA VASALLO</i> | | 17a. ADDRESS
<i>1024 University Blvd. East</i> | | 17b. CITY
<i>SILVER SPRING, MD.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma of Brain</i>
<i>191X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 yrs</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/11</i> , 19 <i>67</i> , to <i>3/18</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/18</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Raymond T. Benack MD</i> | | DEGREE
<i>MD</i> | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>3/19/69</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Raymond T. Benack MD</i> | | 22e. ADDRESS
<i>4115 Blue Drive, Wheaton, MD</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>3-21-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Rock Creek Cemetery</i> | | 23d. LOCATION (City or Town)
<i>Washington</i> | | (County)
<i>D. C.</i> | | (State) | |
| 24. FUNERAL DIRECTOR
<i>FRANCIS J. COLLINS</i> | | | | | | 25a. REC'D BY REGISTRAR
<i>MAR 24 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Jordan</i> | | | |
| 500 University Blvd. W. Silver Spring, Md. | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|-------------------------------|--|
| 04198 | | 04190 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
WILBUR Boyd Perine | | 2a. DATE OF DEATH
Month Day Year
March 14 1969 | | 2b. HOUR
4:45 AM | | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
December 19, 1893 | | 6. AGE (In years last birthday)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Indiana | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. America | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | Md. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San + Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Radio Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
263 Congressional Lane | | #602 | |
| 14. FATHER'S NAME
First Middle Last
Horace G. Perine | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Jennie Jenner | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
Yes | | 16b. SOCIAL SECURITY NO.
578-44-7743 | | 17. INFORMANT
Pt's chart | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Insufficiency
4124
DUE TO, OR AS A CONSEQUENCE OF
(b) Anteroselectic Cardiovascular Disease
3 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 weeks | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Partial Small Bowel Obstruction + Ulceration | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1965, 19, to March 14, 1969, that (I) (we) last saw the deceased alive on March 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
James M. Whitlock | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
James M. Whitlock | | 22e. ADDRESS
7212 Carroll Ave Takoma Park Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
Burial | | 23b. DATE
3/18/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION (City or Town) (County) (State)
Prince George, Md. | | | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler | | ADDRESS
1331 Rockville Pike
Rockville, Maryland | | 25a. REC'D BY REGISTRAR
DATE MAR 21 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jagger | | | | | |



04193

Wilson

Male

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

04199

04191

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) Herbert | | | First Middle Last | | | 2a. DATE OF DEATH
Month 3 Day 26 Year 69 | | | 2b. HOUR
7:00 P.M. | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
11/27/00 | | | 6. AGE (In years last birthday)
69 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
Russia | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery County Md. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Salesman | | | 12b. KIND OF BUSINESS OR INDUSTRY
Shoe-Store | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Silver Spring | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
KARL | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME
UNKNOWN | | | First Middle Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
577-28-1306A | | | 17. INFORMANT
Mrs. Sally Phillips Address Same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bacterial Bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b) Diffuse interstitial pulmonary fibrosis 6 months
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Myeloid Leukemia 10 years | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10 , 19 63 , to 3/26 , 19 69 , that (I) (we) last saw the deceased alive on 3/26 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M. W. Shapiro, M.D. | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
3/27/69 | | |
| 22d. PHYSICIAN'S NAME (Type)
M. W. SHAPIRO, M.D. | | | | | | 22e. ADDRESS
8107 EAST W. AVENUE SILVER SPRING, MD. | | | | | |
| 23a. BURIAL, CREMATION, or MOVING (Specify)
BURIAL | | | 23b. DATE
3-28-69 | | | 23c. NAME OF CEMETERY OR CREMATORY
NATIONAL MEMORIAL PARK | | | 23d. LOCATION (City or Town) (County) (State)
FALLS CHURCH VA | | |
| 24. FUNERAL DIRECTOR
GOODBYE FUNERAL HOME 4217 9TH ST. N.W. | | | | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
APR 1 1969 | | |
| | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|---|---|--|-------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04200 CERTIFICATE OF DEATH 04192 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR |
| Malissa | | | Ann | | | Phillips | | | March 11 1969 2:57 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| Female | | Caucasian | | 11 March 1969 | | | — YRS. | | 7 52 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Virginia | | United States | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Bethesda | | | Naval Hospital | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Virginia | | | Prince William | | Woodbridge | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 664 Bayvue Ave. Apt. 14 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Ronald L Phillips | | | Karen Gunter | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | | | Ronald L. Phillips 664 Bayvue Ave. Woodbridge Va. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis compatible with hyaline membrane disease | | | | | | | | | |
| 7761 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that XX (this hospital) attended the deceased from 11 March, 1969, to 11 March, 1969, that X (we) last saw the deceased alive on 11 March 1969, and that in XX (our) opinion death occurred on the date and hour and from the causes stated above XX (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | |
| Bernard Jay BORTZ, M. D. | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 13 March 1969 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | |
| Bernard Jay BORTZ, M. D. | | | | | | Naval Hospital, Bethesda Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3-17-69 | | Arlington National Cemetery Arlington, Virginia | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. MADE BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert A. Pumphrey Funeral Home 7557 Wisconsin | | | | Bethesda Md. 19 1969 | | | | | |

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04201

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04193

| | | | | | | | | | |
|--|---------------------|--|---|---|---|---|---|--|-----------------------------------|
| 1. DECEASED-NAME
(Type or Print) ADOLF HERMAN PLACK | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 30 Year 69 | | | 2b. HOUR 8:45 AM | | | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
10-29-96 | 6. AGE (In years last birthday)
72 YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. | 2c. DATE PRONOUNCED DEAD
Month 3 Day 30 Year 1969 | | | 2d. HOUR
8:45 AM |
| 7a. BIRTHPLACE (State or foreign country)
GERMANY | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San & Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY PR. GEO | | 13c. CITY OR TOWN
ADELPHI | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3100 Buck Lodge Rd. | |
| 14. FATHER'S NAME
First PLACK Middle PLACK Last PLACK | | | 15. MOTHER'S MAIDEN NAME
First Net Middle AVAILABLE Last AVAILABLE | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
MRS HELENE J. PLACK | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Heart Disease
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerotic Heart Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Read | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
3/30/1969 | | | |
| EXAMINER'S NAME (Type)
BELDEN R. READ, M.D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
April 1, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Adelphi Pr Geo. Md | | |
| 24. FUNERAL DIRECTOR
Interma Funeral Home Inc J A Walters, 254 Canal St Nfc | | | 25a. REC'D BY REGISTRAR
DATE APR 2 1969 | | | 25b. REGISTRAR'S SIGNATURE
J Charles J... | | | |

04201

MEDICAL EXAMINING & CERTIFICATE OF DEATH

FURNISHING OF VITAL RECORDS - THE PHARMACY DEPARTMENT, WASHINGTON, D.C.

DATE

FURNISHING OF VITAL RECORDS - THE PHARMACY DEPARTMENT, WASHINGTON, D.C.

FURNISHING OF VITAL RECORDS - THE PHARMACY DEPARTMENT, WASHINGTON, D.C.

BIRTH

DEATH

MARRIAGE

DATE

M

W

D

Y

DECEASED

US

WASHINGTON, D.C.

WASHINGTON, D.C.

1100 First Lodge St.

P. 2100

WASHINGTON, D.C.

Page 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARTLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04202 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 04194 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | |
| LILA | | | MAY INGRAM POKORSKI | | | March 22 1969 | | 4:31pm | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Female | | White | | July 30, 1901 | | 67 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| West Virginia | | United States | | | | Montgomery County, Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| Olney | | Montgomery General Hospital | | Analyst | | Government | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | Howard | | Highland | | P.O. Box 25 | | | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| William Ingram | | | Charlotte A Stevenson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
Address | | | |
| No. | | | 236-32-4219 | | | Richard G. Pokorski P.O.Box 25 Highland, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Atelectasis, Left lower lobe</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pulmonary infection, Rt. lower lobe</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Carcinoma of lung & metastasis</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 1621 | | | | | | | | 1 wk. | |
| Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | 10 days. | |
| | | | | | | | | ? 3 mos. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? <u>yes.</u> | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1969</u> , to <u>Mar 22, 1969</u> , that (I) (<u>we</u>) lost
saw the deceased alive on <u>3-22-1969</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the
causes stated above, (I) (<u>we</u>) (did) (<u>did not</u>) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Fredrich M. M. M.</u> | | | | 22c. DATE SIGNED
<u>3-23-69</u> | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | | 22e. ADDRESS
<u>Medical Center, Sandy Sp. Ind.</u> | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3/27/69 | | Wildwood Cemetery | | Beckley, West Virginia | | | |
| 24. FUNERAL DIRECTOR
ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Laurel Funeral Home Inc. of 550 Washington Blvd.
Howard M. Fleck | | | | Laurel, Md. 20810 | | DATE <u>27 1969</u> | | <u>Charles Judge</u> | |

04303

OFFICE OF THE

WYOMING

NOT

WYOMING

Widow's Company

Widow's Company, Inc. 1000 Broadway, New York, N.Y. 10003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04203

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04195

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|---|---|---|---|---|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) BERTHA | | | First | Middle | Last | 2a. DATE OF DEATH
Month 3 Day 18 Year 69 | | | 2b. HOUR
4:05 A.M. | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
10-23-1882 | | | 6. AGE (In years last birthday)
86 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
5741 GROSVENOR LANE N.W. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
FACTORY WORKER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
301 PIPING ROCK RD. | | |
| 14. FATHER'S NAME
First Theodore Middle Koldewey Last | | | 15. MOTHER'S MAIDEN NAME
First Wilamena Middle Faml Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
214-16-8718 | | 17. INFORMANT
WM. R. PORTER (SON) | | | Address
BOX 359 LAUREL, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4109 IMMEDIATE CAUSE (a) acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) chronic | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 hours
chronic | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State
2104 69 717 69 | | | | | | | |
| 22a. I certify that TH (this hospital) attended the deceased from 3/19 , 19 69 , to 3/18 , 19 69 , that (I) (we) last saw the deceased alive on 3/19 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Janet A. Mocowitz | | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type)
Janet A. Mocowitz | | | | | | 22e. ADDRESS
Bethesda, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-20-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore City Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard 4107 Wilkens Avenue 21229 | | | | | | 25a. REC'D BY REGISTRAR
MAR 20 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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UNITED STATES OF AMERICA

DEPARTMENT OF COMMERCE

OFFICE OF THE SECRETARY



04204

CERTIFICATE OF DEATH

04196

| | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) Edna Earl Posey | | | 2a. DATE OF DEATH
Month 3 Day 26 Year 69 | | | 2b. HOUR
9 P M | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
7-4-82 | | 6. AGE (in years last birthday)
86 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San & Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
At Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Takoma Park | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
7667 Maple Ave # 212 | |
| 14. FATHER'S NAME First Middle Last
Edward J. Twiford | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Annie Wilton -- Millicent | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
Myrtle Posey, Dau, As Above Item #13 | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) coronary atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) generalized arteriosclerosis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 min.
20 yrs
30 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1962 to March 21 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] MD | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/26/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
H. F. Kreuzburg | | 22e. ADDRESS
7852 16th St. NW Wash DC | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/25/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, 5130 Wis. Ave., N.W. Washington, D.C. | | | | 25a. REC'D BY REGISTRAR
MAR 26 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04204

CERTIFICATE OF DEATH

AT HOME

WILLIAM

1901

WILLIAM, Maryland

John Will Gentry

WILLIAM

WILLIAM

Joseph Gentry's Son, 210 W. Ave.,

Washington, D.C.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|-------------------------|--|--|---|-------------------------------------|--|---|---|--|
| 1. DECEASED-NAME
(Type or Print)
DORIS J. POTTER | | | 2a. DATE KNOWN OF DEATH
Month 3 Day 15 Year 1969 | | | 2b. HOUR
6:35A | | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
Aug. 25, 1896 | 6. AGE (In years last birthday)
72 YRS. | IF UNDER 1 YEAR
MONTHS
0 | IF UNDER 24 HRS
DAYS
0 | IF UNDER 24 HRS
HOURS
0 | IF UNDER 24 HRS
MIN.
0 | 2c. DATE PRONOUNCED DEAD
Month March Day 15 Year 1969 | 2d. HOUR
6:35A |
| 7a. BIRTHPLACE (State or foreign country)
Chicago, Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | |
| 10. CITY OR TOWN OF DEATH
Kensington | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
3121 Plyers Mill Rd | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
accountant | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3121 Plyers Mill Road | |
| 14. FATHER'S NAME
First Taylor Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Margaret Middle Young Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
144-10-8814-A | | 17. INFORMANT
ADDRESS
Joseph H. Potter 3121 Plyers Mill Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory failure
950.0
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) due to barbiturate intoxication
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. - P.M. 3-15 1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Deceased, depressed, took an overdose of a barbiturate | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Home | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Peap | | EXAMINER'S NAME (Type)
BELDEN R. PEAP M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | | | ADDRESS (Street, city, town or county)
 | | 22b. DATE SIGNED
3/15/1969 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
Mar 17, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | 23d. LOCATION (City or Town) (County) (State)
Bladensburg P.G. Md | | | |
| 24. FUNERAL DIRECTOR
Shirley E. Gathers | | | | ADDRESS
316 E. Diamond Avenue Gaithersburg, Md, 20760 | | 25a. DATE
MAR 19 1969 | | 25b. REGISTRAR'S SIGNATURE
 | |

20534

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04206

04198

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) Ethel May Prince | | | 2a. DATE OF DEATH
Month March Day 15 Year 1969 | | | 2b. HOUR
4:45 P.M. | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
3-28-82 | | 6. AGE (in years last birthday)
86 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maine | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington Sanitarium-Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Takoma Park | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
7208 Flower Avenue | | 14. FATHER'S NAME
First Farewell Middle Farewell Last Farewell | | 15. MOTHER'S MAIDEN NAME
First ? Middle ? Last ? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
577-38-0016T | | 17. INFORMANT
Records Washington Sanitarium-Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute arteriosclerotic heart disease
4444
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Shock
DUE TO, OR AS A CONSEQUENCE OF
(c) CNF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
Swiss
6-72 mol | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month: Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
Office Building, Etc. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 1968 , to March 25, 1969 , that (I) (we) last saw the deceased alive on March 9, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
R. H. Sandstrom M.D. | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/15/69 | |
| 22d. PHYSICIAN'S NAME (Type)
R. H. Sandstrom M.D. | | | | 22e. ADDRESS
7701 Carroll Ave Takoma Park, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-19-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Bladensburg, Maryland | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE MAR 24 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4
45M

| 04207 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | CERTIFICATE OF DEATH | | 04199 | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | |
| JAMES | | E. | | QUEEN | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 20. DATE OF DEATH | |
| MALE | | WHITE | | 9/5/96 | | Month Day Year
MARCH 11 1969 | |
| 70. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 6. AGE (In years last birthday)
72 YRS. | |
| N. CAROLINA | | USA | | | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BETHESDA | | SUBURBAN | | Builder | | Construction | |
| 130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| MARYLAND | | MONTGOMERY | | BETHESDA | | | |
| 14. FATHER'S NAME First Middle Last | | 15. MOTHER'S MAIDEN NAME First Middle Last | | 13e. STREET AND NUMBER | | | |
| JOHN M. QUEEN | | MARY ELLEN QUEEN | | 9410 FERNWOOD ROAD | | | |
| 160. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| yes | | 458-10-9842 | | NORMAN QUEEN - SON - | | 4074 ADAMS DRIVE SILVER SPRING | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 4109 | | IMMEDIATE CAUSE (a) - Cerebral Thrombosis | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (b) Rupture myocardium | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (c) myocardial infarction | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | Thrombosis of coronary artery. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20c. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 210. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 6, 1969, to date, 19, that (I) (we) last saw the deceased alive on March 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John G. Ball M.D. DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11 March 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type) John G Ball | | 22e. ADDRESS 7936 Old Georgetown Rd Bethesda, Md | | | | | |
| 230. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 3-14-69 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | 23d. LOCATION (City or Town) (County) (State) Rockville Mont Md | |
| Burial | | | | | | | |
| 24. FUNERAL DIRECTOR Robert A Pumphrey | | 7557 Wisconsin Ave Bethesda, Maryland | | 250. REC'D BY REGISTRAR MAR 14 1969 | | 25b. REGISTRAR'S SIGNATURE William J. Gedge | |

04207

CLINICAL OF DEATH

WILLIAM STANTON UNIVERSITY - IN

04207

1000-1000

1000-1000

1000-1000

1000-1000

John C. Hall

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|--|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 04208 | | | | | | | | | |
| 04200 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Mayer D. Rapoport | | | | | 2a. DATE OF DEATH
Month Day Year
March 29 1969 | | | 2b. HOUR
7:20 PM | |
| 3. SEX
Male | | 4. RACE
Cau | | 5. DATE OF BIRTH
2/19/96 | | 6. AGE (In years
last birthday)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (State or foreign
country)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Holy Cross | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
ret. merchant | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
Maryland | | 13b. COUNTY
Montgomery Maryland | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
First Middle Last
David Rapoport | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Sara Guberman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown)
yes | | (If yes give war or dates of service)
WW I | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
May Rapoport 8201 16th St., SS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4123 IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency of minor</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) <u>Coronary artery disease.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>3 yrs</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , 19 <u>66</u> , to <u>3/29/69</u> , 19 <u>69</u> ; that (I) (we) last
saw the deceased alive on <u>3/25</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Bernard J. Walsh</u> | | | | DEGREE
ATTENDING
PHYS. | | <input checked="" type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3/29/69</u> | |
| 22d. PHYSICIAN'S
NAME (Type)
Bernard J. Walsh | | | | 22e. ADDRESS
<u>1800 Eye St. S.E.</u> | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
4/1/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Adas Israel Cong. | | 23d. LOCATION (City or Town) (County) (State)
Wash., D. C. | | | |
| 24. FUNERAL DIRECTOR
Bernard Danzansky & Sons
3501 14th St., N.W., Wash., D.C. | | | | 25a. REC'D BY REGISTRAR
DATE APR 7 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|--|---|---|--|---|---------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 04209 | | | | | 04201 | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| First Mary Middle Elizabeth Last Reed | | | | | March Month 13 Day 1969 | | | 3:45 P M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH July 23 1903 | | 6. AGE (In years last birthday) 65 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH Woodfield | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. 2 Gaithersburg | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Woodfield | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Box 319 | |
| 14. FATHER'S NAME First Charles Middle Arnold Last Gray | | | 15. MOTHER'S MAIDEN NAME First Emma Middle Gray Last Gray | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address Herman Reed Poolesville Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
180X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Metastases to osseum & lungs
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma of Cervix
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days
18 mos
3 1/2 years | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
arteriosclerotic heart disease - asthma | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE L.S. Batman MD DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 3-17-69 | | | |
| 22d. PHYSICIAN'S NAME (Type) Louisa S. Batman | | | | | 22e. ADDRESS Damascus Md. | | | | | |
| 23a. BURIAL, CREMATION, REINTERMENT Buried | | 23b. DATE March 17 1969 | | 23c. NAME OF CEMETERY OR CREMATORY Forest Oak | | 23d. LOCATION (City or Town) (County) (State) Gaithersburg Mont. Md. | | | | |
| 24. FUNERAL DIRECTOR Francis H. Barber ADDRESS Laytonville Md. | | | | | 25a. REC'D BY REGISTRAR MAR 19 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

1950

1951

13

March

Wed

Elizabeth

Mary

White

Female

July 23

1903

61

Northway

U.S.A.

Id.

Housewife

At. S. McIntosh

Goodfield

43 Box 319

Goodfield

Mont.

Id.

Gray

Summa

Arnold

Barber

Nextman Goodfield

Id.

Id. Kansas

Louisa B. Bateman

Id. Delahoussery

Forest Id. March 17 1900

Id. Barber

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| Item 23 Film 410 3/26/69 | | | | | | | | | | MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04202 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|
| Items 13 taken from birth certif. | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Baby Boy | | | | | | | | | | Middle Last REEDY | | | | | | | | | | 2a. DATE OF DEATH 3 Month 15 Day 69 Year | | | | | | | | | | 2b. HOUR 3:47 M | | | | | | | | | |
| 3. SEX Male | | | | | 4. RACE White | | | | | 5. DATE OF BIRTH 3-15-69 | | | | | 6. AGE (In years last birthday) — YRS. | | | | | IF UNDER 1 YEAR MONTHS — DAYS — | | | | | IF UNDER 24 HRS. HOURS — MIN 2 | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Olney | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | | 13b. COUNTY Montgomery | | | | | 13c. CITY OR TOWN Poolesville | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER Rt. 1, Box 67 | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Carl Middle Edward Last Roberts | | | | | 15. MOTHER'S MAIDEN NAME First Patricia Middle Ilene Last Bentley | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address Medical Records, MGH, Olney, Maryland | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Immaturity
777x
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Chester Wagstaff | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED 3-17-69 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Chester Wagstaff, MD | | | | | 22e. ADDRESS Medical Center, Sandy Spring, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | | | | 23b. DATE 3/15/69 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Hunter Laboratory | | | | | 23d. LOCATION (City or Town) (County) (State) 915 19th St. N.W. Wash. D. C. | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR DATE MAR 19 1969 | | | | | 25b. REGISTRAR'S SIGNATURE William J. ... | | | | | | | | | | | | | | | | | | | | | | | | |

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
30M REV.

| 04211 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04203 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 20. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| KATHERINE MACLEAN | | | | | | | | | | MARCH 12 69 | | | | | | | | | | 10 ³⁰ A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR | | | | | | | | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Female | | | | | | | | | | White | | | | | | | | | | Nov. 6, 1886 | | | | | | | | | | 82 YRS. | | | | | | | | | | MONTHS | | | | | | | | | | DAYS | | | | | | | | | | HOURS | | | | | | | | | | MIN. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nova Scotia | | | | | | | | | | USA | | | | | | | | | | WIDOWED | | | | | | | | | | Montgomery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rockville | | | | | | | | | | 4804 Jasmine Drive | | | | | | | | | | Housewife Ret. | | | | | | | | | | USA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Montgomery | | | | | | | | | | Rockville | | | | | | | | | | YES | | | | | | | | | | 4804 Jasmine Drive | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| George Maclean | | | | | | | | | | Mary MacDonald | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | None | | | | | | | | | | Unknown | | | | | | | | | | Mrs. Lillias R. Cobb | | | | | | | | | | 4804 Jasmine Dr | | | | | | | | | | Rockville, Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4109 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| myocardial infarction | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cronary arteriosclerosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES | | | | | | | | | | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | HOUR A.M. Month Day Year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | P.M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION | | | | | | | | | | Street or R.F.D. No. | | | | | | | | | | City or Town | | | | | | | | | | County | | | | | | | | | | State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1968, to March 1969, that (I) (we) last saw the deceased alive on April 20 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Harold W. Draper M.D. | | | | | | | | | | 12 March 69. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HAROLD W. DRAPE M.D. | | | | | | | | | | 9801 Georgia Ave, Silver Spring, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) | | | | | | | | | | (County) | | | | | | | | | | (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | March 12, 1969 | | | | | | | | | | Fort Lincoln Cemetery | | | | | | | | | | Bladensburg | | | | | | | | | | Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| W. W. Chambers Co | | | | | | | | | | 8455 Ga Ave | | | | | | | | | | DATE | | | | | | | | | | MAR 20 1969 | | | | | | | | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | Silver Spring, Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Clerk to the Coroner

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1-14
45M - 1989

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04212

04204

| | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|-----------------------------|--|-----------------------------|---|--|--|--|
| 1. DECEASED-NAME (Type or print) <i>Gracie I. Keymore</i> | | | 2a. DATE OF DEATH <i>March 9 1969</i> | | | 2b. HOUR <i>3:30 PM</i> | | | | | | | | | | |
| 3. SEX <i>M.</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>2/23/21</i> | | | 6. AGE (In years last birthday) <i>48</i> YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Minn.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <i>Montgomery</i> | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Personnel Director</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Gov. of Md.</i> | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Rockville</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>615 Blossom Drive</i> | | | | | | | | |
| 14. FATHER'S NAME First <i>George</i> Middle <i>Reynolds</i> Last <i>Keymore</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Josephine</i> Middle <i>Northampton</i> Last <i>Keymore</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i> | | | | | | | 16b. SOCIAL SECURITY NO. <i>472-16-8757</i> | | 17. INFORMANT <i>Mary Susan Keymore wife</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Exsanguination</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Large Gastric Ulcer - Gastric Artery</i>
(b) <i>Large Gastric Ulcer - Gastric Artery</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs.</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>3/9/68</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Mammary Gland</i> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year <i>3/9/69</i> P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/9/69</i> to <i>3/9/69</i> , that (I) (we) last saw the deceased alive on <i>3/9/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Richard C. Myers</i> | | DEGREE <i>MD</i> | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>3/9/69</i> | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Richard C. Myers</i> | | 22e. ADDRESS <i>8512 Old Georgetown Road Bethesda, Maryland</i> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, RECOVERY (Specify) | | 23b. DATE <i>3-12-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i> | | | | 23d. LOCATION (City or Town) (County) (State) <i>Rockville Maryland</i> | | | | | | | | |
| 24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i> ADDRESS <i>7557 Wisc. Ave Beth Md</i> | | | | | | | | | | | | | | | | |
| 25a. RECEIVED BY REGISTRAR <i>14 1969</i> 25b. REGISTRAR'S SIGNATURE <i>Richard S. Judas</i> | | | | | | | | | | | | | | | | |

04515

CERTIFICATE OF DEATH

RECEIVED BY THE STATE OF NEW YORK, DEPARTMENT OF HEALTH, ALBANY, N.Y.

Albany, N.Y.

8515 Old Georgetown Road
Bethesda, Maryland

Burial 3-12-69

Rockville Cemetery

Rockville, Maryland

Robert A. Humphrey 7557 Wisc. Ave. Beth Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last
AZOR JACKSON RHEA | | | 2a. DATE OF DEATH
Month Day Year
MARCH 14, 1969 | | 2b. HOUR
4:05 PM | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
11 JANUARY 1903 | | 6. AGE (In years last birthday)
66 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
ALABAMA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
NAVAL HOSPITAL BETHESDA | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
U.S. MARINE CORPS | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
N.C. | | 13b. COUNTY
Carteret | | 13c. CITY OR TOWN
BEAUFORT | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1537 Ann Street | |
| 14. FATHER'S NAME
First Middle Last
William Sampson Rhea | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
(Unknown) Herring | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give one year or dates of service)
YES | | 16b. SOCIAL SECURITY NO.
1931-1953 | | 16c. SOCIAL SECURITY NO.
237-54-1148 | | 17. INFORMANT Annie Rhea-wife Address
1537 Ann St., Beaufort, N.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal Aortic Aneurysm
441.2 DUE TO, OR AS A CONSEQUENCE OF Massive Retroperitoneal Hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary resection of Abd. Aortic Aneurysm
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 26 FEB , 19 69 , to 14 MAR , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 14 MARCH , 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
W.E. Beasley III M.D. | | | | 22c. DATE SIGNED
3-15-69 | | 22d. ADDRESS
Naval Hospital, Bethesda, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3-19-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Elmwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Birmingham, Alabama. | | | |
| 24. FUNERAL DIRECTOR R.A. Pumphrey for ADDRESS
Johns Ridout, 2116 S. 8th St., Birmingham, Ala. | | | | 25a. REC'D BY REGISTRAR
MAR 20 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

4212

STATE OF TEXAS

JOHN JACKSON JR.

CHICAGO

NEW YORK

ATTEST: JAMES J. JAMES

NOTARY

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

CHICAGO

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04206 | |
|--|-------------------------|---|---|---|--|--|---|---|--|---|-------------------------------------|
| 04214 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First
PERLA | | Middle
GOLBY | | Last
RIDGATE | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 3-18 19 69 | | 2b. HOUR
8⁰⁰ P |
| 3. SEX
Female | 4. RACE
Cauc. | 5. DATE OF BIRTH
Mar. 14, 1889 | | 6. AGE (In years
last birthday)
80 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year
March 18 1969 | | 2d. HOUR
9⁰⁰ P |
| 7a. BIRTHPLACE (State or foreign
country)
Penn | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH
Kensington | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Carroll Hall Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
D. C. | | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1225 L St., N. W. | | |
| 14. FATHER'S NAME
First Middle Last
Unknown | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Unknown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
Unknown | | 17. INFORMANT
Walter Gilcrest (Atty) | | | ADDRESS
1317 F. St.
N. W. WashDC | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Insufficiency acute.
4123
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. }
(b) Cardio Vascular Disease.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Sudden

years. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL
SIGNATURE
John G. Ball | | EXAMINER'S
NAME (Type)
JOHN G. BALL | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
March 19, 1969 | | ADDRESS (Street, city, town, or county) Bethesda, Maryland | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
3025-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City or Town) (County) (State)
Arlington Virginia | | | | | |
| 24. FUNERAL DIRECTOR
Robert A Pumphrey | | | | ADDRESS
7557 Wisconsin Ave
Bethesda, Md | | 25a. REC'D BY REGISTRAR
DATE APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|--|--|-------------------------|---|------------------------------------|--|---|--|--|--|--|--|--|--|------------------------------------|--|
| 1. DECEASED-NAME
(Type or print) INFANT MALE RIGGS | | | 2a. DATE OF DEATH
Month MARCH Day 15 Year 1969 | | | 2b. HOUR
11:30 P.M. | | | | | | | | | |
| 3. SEX
MALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
3/15/69 | | | 6. AGE (In years last birthday)
YRS. — | | IF UNDER 1 YEAR
MONTHS — DAYS — | | IF UNDER 24 HRS.
HOURS 36 MIN — | | | | |
| 7a. BIRTHPLACE (State or foreign country)
BETHESDA MD | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY | | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SUBURBAN | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | | 13c. CITY OR TOWN
CATHERS | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
RT 3 - BOX 43 | | | |
| 14. FATHER'S-NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Eloise Riggs | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anoxia
7769
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Immaturity
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Premature labor | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Dr. Charles M. Murr | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | | MED. DIRECTOR <input type="checkbox"/> | | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/16/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) | | | 23b. DATE
3/18/69 | | | 23c. NAME OF CEMETERY OR CREMATORY
Suburban Hospital | | | 23d. LOCATION (City or Town) (County) (State)
Bethesda - Montg. - Md. | | | | | | |
| 24. FUNERAL DIRECTOR
Mrs. Amelia C. Carter, Ammichtatog | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
MAR 24 1969 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04812

THE NATIONAL ARCHIVES
COLLEGE PARK, MARYLAND 20740

James M. Smith
1890-1960

President of the
National Academy of Sciences

1961/12 x 1961/12
James M. Smith

1961/12 x 1961/12
James M. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04216

CERTIFICATE OF DEATH

04208

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED-NAME
(Type or print) Charles Paunelle Roane Jr. | | | 2a. DATE OF DEATH
Month Day Year
March 25 1969 | | 2b. HOUR A
7:30 M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
29 September 1952 | | 6. AGE (In years last birthday)
16 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Washington, DC | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
The Clinical Center | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Bethesda | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
8620 Hempstead Avenue | |
| 14. FATHER'S NAME First Middle Last
Charles Paunelle Roane Sr. | | 15. MOTHER'S MAIDEN NAME First Middle Last
Dale Hedrick | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT The Medical Records Address
The Clinical Center, NIH, Bethesda, Md. 20014 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia, probable staphylococcal</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Septicemia with shock</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Acute lymphocytic leukemia</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days
3 days
1 month |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>11 March</u> , 19 <u>69</u> , to <u>25 March</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>25 March</u> , 19 <u>69</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Richard J. Samaha</u> MD | | 22c. DATE SIGNED
25 March 1969 | | 22d. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | |
| 22e. PHYSICIAN'S NAME (Type)
Richard J. Samaha | | 22f. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-28-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Denton Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Denton, Caroline County, Md. | | 23e. LOCATION (City or Town) (County) (State)
Denton, Caroline County, Md. | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016 | | 25a. REC'D BY REGISTRAR
APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>William J. Jones</u> | |

1. The following information was obtained from the records of the Federal Bureau of Investigation, Bureau of Prisons, and the United States Department of Justice, Office of the Inspector General, regarding the activities of the following individuals:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Cleared By Dr. Rep. 15-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04217

CERTIFICATE OF DEATH

04209

| | | | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Claudia S. Robertson</i> | | | 2a. DATE OF DEATH
Month <i>3</i> Day <i>23</i> Year <i>69</i> | | | 2b. HOUR
<i>11:15</i> M | | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>W.H.</i> | | 5. DATE OF BIRTH
<i>1-7-86</i> | | 6. AGE (In years last birthday)
<i>83</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
<i>md</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>US</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>montgomery</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Holy Cross</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Self Employed</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>md.</i> | | 13b. COUNTY
<i>montgomery</i> | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>10710 Huntley Ave.</i> | | | |
| 14. FATHER'S NAME
First <i>Samuel L.</i> Middle <i>Robertson</i> Last | | | 15. MOTHER'S MAIDEN NAME
First <i>Alice A.</i> Middle <i>Ricketts</i> Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>213-48-1323</i> | | 17. INFORMANT
<i>Cooke A. Robertson-10710 Huntley Ave.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary infarction</i>
<i>887X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>9 other</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>Arteriosclerotic heart disease - Broncho pneumonia</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>3-19-69</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Fracture R. hip</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>3-19 1969</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
<i>Fall at home</i> | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
<i>Home</i> | | 21f. LOCATION Street or R.F.D. No. City or Town County State
<i>10710 Huntley Ave. Mont. Md</i> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Mar 19</i> , 19 <i>69</i> , to <i>Mar 23</i> , 19 <i>69</i> , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on <i>March 24 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Roland J. Cavanaugh</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>Roland J. Cavanaugh</i> | | 22e. ADDRESS
<i>1015 Spring St., Silver Spring, Md.</i> | | 22c. DATE SIGNED
<i>March 24</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>3/27/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Rockville</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Rockville, Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>Tyson Wheeler Funeral Home-1331 Rockville Pike</i> | | 25a. REC'D BY REGISTRAR
<i>MAR 26 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Clara J. Jordan</i> | | | | | | | |

04217

RECEIVED OF BUREAU

Self-employed

1010

John A. Edwards

John A. Edwards

212-68-123

John A. Edwards

John A. Edwards

John A. Edwards

John A. Edwards

John A. Edwards

John A. Edwards

John A. Edwards

John A. Edwards

John A. Edwards

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VR A15 (4)
30M REV. 1/78

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|---|---|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04218 | | | | | | | | | |
| 04210 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
First Middle Last
William Orem Robinson | | | | | | 2a. DATE OF DEATH
Month Day Year
March 21 1969 | | 2b. HOUR AM
12:59 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
8 November 1959 | | 6. AGE (In years last birthday)
9 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
None | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
STATE Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
10215 Woodmoor Circle | |
| 14. FATHER'S NAME
First Middle Last
Thomas G. Robinson | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Virginia Gardner | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
None | | 17. INFORMANT The Medical Records Address
The Clinical Center, NIH, Bethesda, Md. 20014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory arrest
2049 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Leukemia - lymphosarcoma
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 minutes
10 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 18 March, 1969, to 21 March, 1969, that (X) (we) lost the deceased alive on 21 March, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Alan Snyder DEGREE | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
21 March 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Alan L. Snyder, M.D. | | | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-25-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR
Francis J. Collins | | | | 500 University Blvd. W.
Silver Spring, Md. | | 25a. REC'D BY REGISTRAR
MAR 27 1969
DATE | | 25b. REGISTRAR'S SIGNATURE
Francis J. Collins | |

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | |
| Eugene | | L. | | Rocca | | MARCH 23 1969 | | 2b. HOUR
3:19 A M | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
Jan. 29, 1902 | | 6. AGE (In years last birthday)
67 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | Md. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Potomac Valley N.H. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
D.C. | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Wash., D.C. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4224 Military Road, N.W. | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | |
| John | | B. | | Rocca | | Assunta | | L. Casassa | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
579-60-88117 | | 17. INFORMANT
Ray Rocca, 3350 Tennyson St, NW, Wash., D.C. | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis, Metastatic
185X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prostatic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 yrs
6 yrs + | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (the hospital) attended the deceased from Feb 1963, to Mar 23, 1969, that (I) (we) last saw the deceased alive on Mar 20 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Michel M. Healy, M.D. | | 22c. DATE SIGNED
3/23/69 | | 22d. PHYSICIAN'S NAME (Type)
Michel M. HEALY, M.D. | | 22e. ADDRESS
5411 W. Cedar La., Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/26/69 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Washington, D.C. | | 25a. REC'D BY REGISTRAR
MAR 26 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | | | | | |

04212

OFFICE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Male Casselman Jan. 29, 1902

Rockville, Md. U.S.A. Montgomery

Rockville Potomac Valley N.H. Retired Auto

John B. --- Mrs. H.C. 1902 Military Road, N.W.

Casselman I. Casselman

Rockville, Md. --- Mrs. H.C. 1902

Bureau 1/25/02 St. Mary's Cemetery Washington, D.C.

Joseph Gaylor's home, Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

CERTIFICATE OF DEATH

04220

04212

| | | | | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--------|--|-------|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
MARK ALAN ROLAND | | | 2a. DATE OF DEATH
Month Day Year
MARCH 25 1969 | | | 2b. HOUR
9 ⁰⁰ A M | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MARCH 25, 1969 | | 6. AGE (In years last birthday)
— YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
3 25 | | IF UNDER 24 HRS.
HOURS MIN.
3 25 | | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery County Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
P. G. | | 13c. CITY OR TOWN
Bowie | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
12813 Beechtree Lane | | | | |
| 14. FATHER'S NAME
First Middle Last
Daniel Patrick Roland | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Rebecca NMN Bryant | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO.
NINE | | 17. INFORMANT
Address
FATHER DANIEL P. ROLAND 5616 130 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity, severe. (1 lb, 12 ozs) 3 hrs 25 min
777X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION
Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 25, 1969, to MARCH 25, 1969, that (I) (we) last saw the deceased alive on MARCH 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
H. N. Kwok M.D. | | | | DEGREE
M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/25/69 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Robert Kwok M.D. | | | | 22e. ADDRESS
Holy Cross Hosp. Silver Spring, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
MARCH 27, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
M.T. Olive T Cem | | 23d. LOCATION (City or Town) (County) (State)
WASHINGTON D.C. | | | | | | |
| 24. FUNERAL DIRECTOR
LANHAM FUNERAL HOME
of ROBERT G. BEALL | | | | ADDRESS
LANHAM, MD. | | 25a. REC'D BY REGISTRAR
DATE
MAR 27 1969 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | |

01330

GENERAL OF DEPT

X

Handwritten signature or initials

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 04221 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04213 | |
| Item 6 Film 410 3/18/69 kk | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Jesse James Roper | | | | 2a. DATE OF DEATH
Month Day Year
March 10 69 | | 2b. HOUR
14 1/2 M | |
| 3. SEX
M | | 4. RACE
Negroe | | 5. DATE OF BIRTH
4-17-1896 | | 6. AGE (In years lost birthday)
72 7/13 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Mont. | |
| 10. CITY OR TOWN OF DEATH
Kensington Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
3000 The Comas Ave. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Tailor | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
D.C. | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
1412 Quincy St. N.W. | | 14. FATHER'S NAME
First Middle Last
Daniel Poricha | | 15. MOTHER'S MAIDEN NAME
First Middle Last
UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) Yes | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) W. U. I. | | 17. INFORMANT
Address
JOHN ROPER-6231 N.D.AVE, D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
2719 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anemia
DUE TO, OR AS A CONSEQUENCE OF (c) Anystemia
3 wks
6 wks | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Alcoholic 4 series dementia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/26/69, 1969, to 3/10/69, that (we) saw the deceased alive on 3/10/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Marvin Wadler M.D. | | | | 22c. DATE SIGNED
3/10/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
MARVIN WADLER | | | | 22e. ADDRESS
8218 Wisconsin Ave. Beth. Md. | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE
3-13-69 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. LUKES CHURCH MONCK'S CORNER, S.C. | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR
Frazier Funeral Home 389 BIA | | | | 25a. REC'D BY REGISTRAR
DATE MAR 14 1969 | | 25b. REGISTRAR'S SIGNATURE
John J. J. | |

04551

CENTRAL BANK OF DENMARK

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the document. Some words like "BANK" and "DANISH" are faintly visible.]

1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|------------------------------|--|---|-------------------|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04222 | | | | | | | | | |
| 04214 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
M |
| ANNE EVA. ROSENFELD | | | | | | MARCH 22 1969 | | | 3 15 |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| FEMALE | | CAUCASIAN | | JULY 10, 1915 | | 53 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| D.C. | | U.S.A. | | | | MONTGOMERY Md. | | | |
| 1d. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| SILVER SPRING | | | HOLY CROSS HOSPITAL | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| MARYLAND | | | MONTGOMERY | | SILVER SPRING | | | | 8510 16 STREET APT 714 |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | |
| SAMUEL | | | | | | SARAH KATZ | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | |
| | | | | | | EUGENE ROSENFELD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DISSEMINATED CARCINOMA OF BREAST
174X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | 8510-16 th ST. #714
SILVER SPRING, MD
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Steroid-induced diabetes mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1960, to 3-22-1969, that (I) (we) last saw the deceased alive on 3-21-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| JASON GEIGER, M.D. | | | | | | | | 3-23-69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | 22f. REGISTRAR'S SIGNATURE | | | |
| JASON GEIGER, M.D. | | | 800 PERSHING DRIVE
SILVER SPRING, MD. | | | J. Charles Judge | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) |
| BURIAL | | | Mar. 24, 1969 | | | King David Memorial Garden | | | Falls Church, VA. |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Donald M. Stein | | | 232 Carroll | | | MAR 26 1969 | | J. Charles Judge | |
| Hebrew Memorial Funeral Home St., N.W. Wash., D.C. | | | | | | | | | |

05540

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|--|--|---|--------|---|---|---|--|---|-------------------------------|
| 04223 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04215 | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
5:45 A. M. | |
| CORA | | | M. | | ROSEWAG | 3 10 69 | | | |
| 3. SEX
F | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
7-4-'78 | | 6. AGE (In years last birthday)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | Md. |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Grosvenor Lane Nursing Home | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
R.L.T. | | 12b. KIND OF BUSINESS OR INDUSTRY
Cable Co | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
District of Columbia | | 13b. CITY OR TOWN
Washington | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1228 EYE ST. N.W. | | | |
| 14. FATHER'S NAME
George N. Walker | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME
Geneva Leonhardt | | First | Middle | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown | | 16b. SOCIAL SECURITY NO.
578-46-9598 | | 17. INFORMANT
Ellenora E. Walker | | Address
1228 Eye St N.W. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial arterial infarction</u>
4442 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>aortic valvular stenosis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 69 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> , 19 <u>69</u> , to <u>3/10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
David A. Howard, M.D. | | | | | 22c. DATE SIGNED
3/10/69 | | 22d. PHYSICIAN'S NAME (Type) | | |
| 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3.12.69 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington D.C. | | | |
| 24. FUNERAL DIRECTOR
Lee Funeral Home 300.4th st N E Wash | | | | | 25a. REC'D BY REGISTRAR
MAR 11 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

04224

CERTIFICATE OF DEATH

| | | | | |
|---|---|---|--|---|
| 1. DECEASED-NAME
(Type or print) JULIA W. Rowe | | 2a. DATE OF DEATH
Month MARCH Day 12 Year 1969 | | 2b. HOUR
12:30 M |
| 3. SEX
FEMALE | 4. RACE
White | 5. DATE OF BIRTH
Dec 17, 1918 | | 6. AGE (In years
last birthday) 50 YRS. |
| 7a. BIRTHPLACE (State or foreign
country) SCOTLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Suburban | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Teacher of Nursing | | 12b. KIND OF BUSINESS OR
INDUSTRY
Nursing |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE DC. | 13b. CITY OR TOWN
Washington | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
Apt. 4817 36th St. N.W. 201 | |
| 14. FATHER'S NAME First Alfred Louis Middle Rowe | 15. MOTHER'S MAIDEN NAME First Joan Middle Dalrymple | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | |
| 16b. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Louis Rowe Address 1100 Hunt Club Drive Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RENAL FAILURE - UREMIA
7341
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) SYSTEMIC LUPUS ERYTHEMATOSUS
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4-6 mo.
10 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
BRONCHOPNEUMONIA AND CONGESTIVE HEART FAILURE | | | | |
| 19a. DATE OF OPERATION
NONE | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
NA | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
NA
19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
NA | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.)
NA | 21f. LOCATION Street or R.F.D. No. City or Town County State
NA | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 7, 1969 , to Feb 12, 1969 , that (I) (we) last
saw the deceased alive on Feb 11, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Howard Levine, M.D. | | DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED
3-12-69 | |
| 22d. PHYSICIAN'S NAME (Type)
HOWARD LEVINE | | 22e. ADDRESS
8216 Wisconsin Ave, Bethesda, Md. | | |
| 23a. BURIAL CREMATION
BURIAL | 23b. DATE
3-14-69 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | 23d. LOCATION (City or Town) (County) (State)
Suitland Pr. Geo Md | |
| 24. FUNERAL DIRECTOR
Robert A Pumphrey | | ADDRESS
7557 Wisconsin Ave
Bethesda, Md | | 25a. REC'D BY REGISTRAR
MAR 14 1969 |
| | | | | 25b. REGISTRAR'S SIGNATURE
William Under |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1
Cleared - med. Examiners

VR A15 (4)
30M REV. 1/68

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|---|--|----------------------------|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|
| 04225 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04217 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Frederick Joseph Roy | | | | | | | | | | 2a. DATE OF DEATH Month Day Year 3 11 69 | | | | | | | | | | 2b. HOUR 3:05 PM | | | | | | | | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH 2/24/95 | | | 6. AGE (In years last birthday) 74 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Wells River Vermont | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Montgomery County Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Accountant | | | 12b. KIND OF BUSINESS OR INDUSTRY Government | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Montgomery | | | 13c. CITY OR TOWN Sil. S rg. | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 13401 Clifton Dr. SSMd. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last Ovide Roy | | | 15. MOTHER'S MAIDEN NAME First Middle Last Mary Picard | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) yes | | | (If yes give war or dates of service) WW I | | | 16b. SOCIAL SECURITY NO. 218 38 9659 | | | 17. INFORMANT wife Margaret 13401 Clifton Dr. SSMd. | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1952 to 11 March 1969, that (I) (we) last saw the deceased alive on 4 March 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE William D. Aud, M.D. | | | | | | | | | | 22c. DATE SIGNED 3/11/69 | | | 22d. PHYSICIAN'S NAME (Type) William D. Aud, M.D. | | | | | | | | | | | | | | | | |
| 22e. ADDRESS 9006 Colesville Rd., Silver Spring, Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 3-15-69 | | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | | 23d. LOCATION (City or Town) (County) (State) Silver Spring, Md | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Francis Hallis 500 University Blvd W Silver Spring, Md | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE MAR 17 1969 | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | |

04332

CENTRAL IN CHARGE

General Order

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>04226</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>04218</div> | | | | | | | | | | | |
|--|--|------------------------------|--|--|------------------------------------|--|--|---|--|------------------|--|
| 1. DECEASED-NAME (Type or print) | | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| <div>First</div> David <div>Middle</div> J. <div>Last</div> Rudolph | | | | | | <div>Month</div> March <div>Day</div> 31, <div>Year</div> 1969 | | | <div>M</div> | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | August 1, 1908 | | 60 | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Pennsylvania | | USA | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Tokoma Park | | | Washington San. & Hosp. | | | Guard-Security-Vitro | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md. | | | Montg | | Rockville | | | | 4318 Aspin Hill Rd. | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last John Rudolph | | | | First Middle Last Lydia Pifer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| No | | | | 191-03-6749 | | Richard J. Rudolph-4318 Aspin Hill Road Rockville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>mitotater Brodigious Corona</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 30</i> , 19 <i>69</i> , to <i>Nov 1</i> , 19 <i>69</i> , that (I) (we) lost the deceased alive on <i>Nov 1</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | | | |
| <i>Lewis Dennis</i> | | | | | | 4/1/69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| Lewis Dennis | | | | | | 3906 Bel Pre Rd. Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 4/4/69 | | Lloyd Cemetery | | | Ebensburg, Pa. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Tyson Wheeler F.H. 1331 Rockville Pike | | | | | | DATE APR 7 1969 | | | <i>Charles Judge</i> | | |
| Rockville, Md. | | | | | | | | | | | |

04330

David

J. L. Lohman

March 27, 1957

White

August 1, 1958

Temporary

USA

John L. Lohman

Washington, D. C.

John

Washington

March 27, 1957

Washington

March 27, 1957

to

1957-1958

Washington, D. C.

John L. Lohman

John Lohman

March 27, 1957

Washington

Washington

Washington, D. C.

March 27, 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04227

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04219

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) Emma Delores Ruscher | | | 2a. DATE OF DEATH
Month March Day 7 Year 1969 | | 2b. HOUR
2:15 PM |
| 3. SEX
Female | 4. RACE
Cauc. | 5. DATE OF BIRTH
Feb. 15, 1888 | | 6. AGE (In years last birthday)
81 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
U.S.A. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Grady Lane Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Reg. Nurse | 12b. KIND OF BUSINESS OR INDUSTRY
Nursing | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Resident before admission) STATE
md. | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
1007 University Blvd. | |
| 14. FATHER'S NAME
First Middle Last | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
220-54-9828 | 17. INFORMANT
Nursing Home records | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) cardiovascular insufficiency | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days
5 days
chronic |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/1 , 19 69 , to 3/1 , 19 69 , that (I) (we) last saw the deceased alive on 2/1 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
David Morowitz | | 22c. DATE SIGNED
3/1/69 | | 22d. PHYSICIAN'S NAME (Type)
David Morowitz | |
| 22e. ADDRESS
9237 Three Oaks Drive, Silver Spring | | 22f. ADDRESS
9237 Three Oaks Drive, Silver Spring | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/5/69 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Prince George Co. Md. |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home | | 25a. REC'D BY REGISTRAR
1351 Rock Pike | | 25b. REGISTRAR'S SIGNATURE
John J. Judge | |
| 25c. ADDRESS
Rockville, Md. | | 25d. DATE
MAR 11 1969 | | 25e. REGISTRAR'S SIGNATURE
John J. Judge | |

04327

1. *Chlorophyll* *Chlorophyll* *Chlorophyll*
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38. *Chlorophyll* *Chlorophyll* *Chlorophyll*
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40. *Chlorophyll* *Chlorophyll* *Chlorophyll*

FOR STATE
HEALTH DEPT.

04228

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04220

| | | | | | | | | | | |
|---|---------|--|--------|--|--------------------------|---|--------------------------|---|----------|--|
| 1. DECEASED NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | Month | Day | Year | 2b. HOUR |
| Ethel T. Satterfield | | | | | X | | 3/24/69 | 19 | | 8:20 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| female | white | April 6, 1878 | | 90 YRS. | MONTHS | DAYS | March 24 | | 8:20 PM | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Ohio | | U.S.A. | | | | Montgomery | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Kensington | | Kensington Gardens Nursing Home | | | | Housewife | | own home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Maryland | | Montgomery | | Kensington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5206 White Flint Drive | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| | | | | Timlin | | | | | unknown | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| | | | | yes | | William Satterfield | | 131 Doolan Court, Florida | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4123 Acute Coronary Insufficiency | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | Belden R. Keap M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | Belden R. Keap M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 3/25/1969 | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| | | | | | | ADDRESS (Street, City, Town or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Cremation | | March 24, 1969 | | St. Lincoln Crematory | | Bladensburg, Maryland | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Warner E. Humphrey, Inc. | | 8434 Georgia Avenue, Silver Spring, Md. | | | | MAR 28 1969 | | Charles Judge | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECORDS SECTION OF THE

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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480 | 1481 | 1482 | 1483 | 1484 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 04229 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04221 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Dallie Lucile Saunders | | | 2a. DATE OF DEATH
Month Day Year
March 11 1969 | | | 2b. HOUR A M
6:30 M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
13 May 1937 | | 6. AGE (In years last birthday)
31 YRS | |
| 7a. BIRTHPLACE (State or foreign country)
Georgia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Virginia | | 13b. COUNTY
Arlington | | 13c. CITY OR TOWN
Arlington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
804 North Cleveland Street | | 14. FATHER'S NAME First Middle Last
Clisby Jewell | | 15. MOTHER'S MAIDEN NAME First Middle Last
Loree Wood | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown
No | | 16b. SOCIAL SECURITY NO.
XXXXXXXXXX | | 17. INFORMANT Bethesda, Maryland 20814
The Medical Records, The Clinical Center. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
7341
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertension, congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Systemic lupus erythematosus, lupus nephritis | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
unknown
unknown | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (A) (this hospital) attended the deceased from 8 January, 1969, to 11 March, 1969, that (X) (we) last saw the deceased alive on 11 March 1969, and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Edward J. Goetzl, M.D., DEGREE | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
11 March 1969 | |
| 22d. PHYSICIAN'S NAME (Type)
Edward J. Goetzl, M.D. | | | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
March 14, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Calvary Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Fairfax, Virginia | |
| 24. FUNERAL DIRECTOR
C.M. Ansel | | ADDRESS
Murphy Funeral Home
Arlington, Virginia 22204 | | 25a. REC'D BY REGISTRAR
DATE
MAR 14 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

44529

(ORIGINAL DATA)

| DATE | TIME | LOCATION | STATUS | REMARKS |
|------|-------|----------|--------|-----------------------|
| 1950 | 10:00 | New York | Active | Initial contact |
| 1950 | 11:00 | New York | Active | Continued observation |
| 1950 | 12:00 | New York | Active | Data recorded |
| 1950 | 13:00 | New York | Active | Analysis in progress |
| 1950 | 14:00 | New York | Active | Final report prepared |
| 1950 | 15:00 | New York | Active | Data archived |
| 1950 | 16:00 | New York | Active | Review completed |
| 1950 | 17:00 | New York | Active | Project closed |
| 1950 | 18:00 | New York | Active | Final summary |
| 1950 | 19:00 | New York | Active | Data backup |
| 1950 | 20:00 | New York | Active | Project review |
| 1950 | 21:00 | New York | Active | Data cleanup |
| 1950 | 22:00 | New York | Active | Project closure |
| 1950 | 23:00 | New York | Active | Final check |
| 1950 | 00:00 | New York | Active | Data transfer |
| 1950 | 01:00 | New York | Active | Project end |
| 1950 | 02:00 | New York | Active | Data backup |
| 1950 | 03:00 | New York | Active | Project review |
| 1950 | 04:00 | New York | Active | Data cleanup |
| 1950 | 05:00 | New York | Active | Project closure |
| 1950 | 06:00 | New York | Active | Final check |
| 1950 | 07:00 | New York | Active | Data transfer |

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04230

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04222

| | | | | | | | | | | | | | | |
|---|---------|------------------|--|-----------------|------|--|------|--------------------------|---|--|-----------|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | Month Day Year | | | 2b. HOUR | | |
| George | | | WILLIAM | | | Schaeffer | | | March 2 1969 | | | 1:35 P.M. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | | |
| M. | W. | May 21, 1885 | 83 YRS. | MONTHS | DAYS | HOURS | MIN. | March 2 1969 | | | 1:35 P.M. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | 9. COUNTY OF DEATH | | | Md. | | |
| Maryland | | | U.S.A. | | | NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | | Suburban | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | | |
| Md. | | | Montgomery | | | Bethesda | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 4809 Steplmo Ave. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | |
| Willaim Schaeffer | | | Mary J. Stone | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | |
| No | | | 212-12-1547A | | | wife | | | Same as Item 13. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Pneumonia -</u> | | | | | | | | | | | | 4 days - | | |
| 887X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture of Hip</u> | | | | | | | | | | | | 15 days | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) <u>Arterio Sclerosis Generalized</u> | | | | | | | | | | | | years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| <u>Parkinson Syndrome</u> | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | | P.M. 2/15 1969 | | | Fell in nursing Home | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | | County | | |
| | | | Nursing Home Grosner | | | Grosner Lane | | | Bethesda | | | Montgomery Md | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | EXAMINER'S NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | |
| John G. Ball | | | JOHN G. BALL | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | Bethesda, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | | (County) (State) | | |
| Burial | | | 3-5-69 | | | Mt. Zion Cemetery | | | Bethesda, Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | MAR 6 1969 | | | f. Charles Judge | | | | | |

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| | | | | | | | | | |
|------------------|--|-----------------------|--|-----------------------|--|-----------------------|--|-----------------------|--|
| NAME | | LAST | | FIRST | | MIDDLE | | SUFFIX | |
| JAMES | | HARRIS | | JAMES | | HARRIS | | JAMES | |
| DATE OF BIRTH | | 10/10/1961 | | 10/10/1961 | | 10/10/1961 | | 10/10/1961 | |
| PLACE OF BIRTH | | NEW YORK | | NEW YORK | | NEW YORK | | NEW YORK | |
| CITY | | NEW YORK | | NEW YORK | | NEW YORK | | NEW YORK | |
| STATE | | NEW YORK | | NEW YORK | | NEW YORK | | NEW YORK | |
| COUNTRY | | UNITED STATES | | UNITED STATES | | UNITED STATES | | UNITED STATES | |
| MILITARY SERVICE | | ARMY | | ARMY | | ARMY | | ARMY | |
| BRANCH | | INFANTRY | | INFANTRY | | INFANTRY | | INFANTRY | |
| GRADE | | PRIVATE | | PRIVATE | | PRIVATE | | PRIVATE | |
| SERIAL NUMBER | | 1000 | | 1000 | | 1000 | | 1000 | |
| UNIT | | 1ST INFANTRY DIVISION | | 1ST INFANTRY DIVISION | | 1ST INFANTRY DIVISION | | 1ST INFANTRY DIVISION | |
| COMPANY | | A | | A | | A | | A | |
| PLATOON | | 1 | | 1 | | 1 | | 1 | |
| BATTALION | | 1 | | 1 | | 1 | | 1 | |
| REGIMENT | | 1 | | 1 | | 1 | | 1 | |
| DIVISION | | 1 | | 1 | | 1 | | 1 | |
| CORPS | | 1 | | 1 | | 1 | | 1 | |
| ARMY | | 1 | | 1 | | 1 | | 1 | |
| NATIONALITY | | AMERICAN | | AMERICAN | | AMERICAN | | AMERICAN | |
| RELIGION | | CATHOLIC | | CATHOLIC | | CATHOLIC | | CATHOLIC | |
| EDUCATION | | HIGH SCHOOL | | HIGH SCHOOL | | HIGH SCHOOL | | HIGH SCHOOL | |
| OCCUPATION | | PRIVATE | | PRIVATE | | PRIVATE | | PRIVATE | |
| MILITARY SERVICE | | ARMY | | ARMY | | ARMY | | ARMY | |
| BRANCH | | INFANTRY | | INFANTRY | | INFANTRY | | INFANTRY | |
| GRADE | | PRIVATE | | PRIVATE | | PRIVATE | | PRIVATE | |
| SERIAL NUMBER | | 1000 | | 1000 | | 1000 | | 1000 | |
| UNIT | | 1ST INFANTRY DIVISION | | 1ST INFANTRY DIVISION | | 1ST INFANTRY DIVISION | | 1ST INFANTRY DIVISION | |
| COMPANY | | A | | A | | A | | A | |
| PLATOON | | 1 | | 1 | | 1 | | 1 | |
| BATTALION | | 1 | | 1 | | 1 | | 1 | |
| REGIMENT | | 1 | | 1 | | 1 | | 1 | |
| DIVISION | | 1 | | 1 | | 1 | | 1 | |
| CORPS | | 1 | | 1 | | 1 | | 1 | |
| ARMY | | 1 | | 1 | | 1 | | 1 | |
| NATIONALITY | | AMERICAN | | AMERICAN | | AMERICAN | | AMERICAN | |
| RELIGION | | CATHOLIC | | CATHOLIC | | CATHOLIC | | CATHOLIC | |
| EDUCATION | | HIGH SCHOOL | | HIGH SCHOOL | | HIGH SCHOOL | | HIGH SCHOOL | |
| OCCUPATION | | PRIVATE | | PRIVATE | | PRIVATE | | PRIVATE | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-8. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04231

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04223

| | | | | | | | | |
|---|----------------------|--|--|---|---|---|--|---|
| 1. DECEASED-NAME
(Type or Print) <i>Keith L. Seegmiller</i> | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year <i>Mar. 9 1969</i> | | | 2b. HOUR <i>6:20</i> | | |
| 3. SEX <i>m.</i> | 4. RACE <i>white</i> | 5. DATE OF BIRTH <i>4/12/02</i> | 6. AGE (In years last birthday) <i>66</i> YRS. MONTHS <i>10</i> DAYS <i>12</i> | IF UNDER 1 YEAR
IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD
Month Day Year <i>Mar. 9 1969</i> | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Utah</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Attorney</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | | 13b. COUNTY <i>Mont.</i> | | 13c. CITY OR TOWN <i>Kennington</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>9615 Hillridge Rd.</i> |
| 14. FATHER'S NAME First Middle Last <i>Charles L. Seegmiller</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Ida Morris</i> | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes give war or dates of service) | | |
| 16b. SOCIAL SECURITY NO. <i>420-34-7806</i> | | | 17. INFORMANT <i>Keith L. Stares</i> | | | ADDRESS <i>3917 Lantern w. V. Stares</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i>
<i>4119</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Sudden</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <i>March 9, 1969.</i> | | |
| EXAMINER'S NAME (Type) <i>John G. Ball</i> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i> | | | | | | | | |
| 23a. BURIAL CREMATION <i>XXXX</i> REMOVAL (Specify) | | 23b. DATE <i>3-13-69</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i> | | | 23d. LOCATION (City or Town) (County) (State) <i>Rockville Md.</i> | | |
| 24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> ADDRESS <i>7557-Wisconsin Ave., Bethesda, Md.</i> | | | | | 25a. REC'D BY REGISTRAR <i>MAR 14 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

7320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|--|--|---|--|--|---|---|--|---|--|
| 04232 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04224 | | | |
| 1. DECEASED-NAME (Type or print) First <u>Phyllis</u> Middle <u>A.</u> Last <u>Seips</u> | | | | | | 2a. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1969</u> | | 2b. HOUR <u>2:24</u> AM | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH <u>May 29, 1893</u> | | 6. AGE (In years last birthday) <u>75</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <u>Illinois</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S. America</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH <u>Montgomery</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH <u>Takoma Park</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington San + Hospital</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>SECRETARY</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> COUNTY <u>Prince George</u> | | 13b. CITY OR TOWN <u>Green belt</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>17-H Parkway</u> | | | |
| 14. FATHER'S NAME First <u>Ross</u> Middle <u>Seips</u> Last <u>Seips</u> | | 15. MOTHER'S MAIDEN NAME First <u>Eleanora</u> Middle <u>de Cesare</u> Last <u>de Cesare</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>578-28-8559</u> | | 17. INFORMANT <u>PT's Chart -</u> | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4123</u> IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 14, 1969</u> , to <u>March 29, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 28, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Boris Robkin</u> | | DEGREE <u>MD</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>3-29-69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u> | | 22e. ADDRESS <u>1019 Union Blvd East Silver Spring</u> | | | | | | | |
| 23a. DATE <u>3-29-1969</u> | | 23b. NAME OF CEMETERY OR CREMATORY <u>ALL SAINTS CEMETERY</u> | | 23c. LOCATION (City or Town) <u>DES PLAINES, ILLINOIS</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>JOSEPH GAULIER & SONS, INC.</u> | | 25a. REC'D BY REGISTRAR <u>APR 7 1969</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |

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[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|---|---|---|--|---|--------------------------------|--------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04233 | | | | | | | | | |
| 04225 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
P M |
| Margaret | | | Selby | | | March 29 1969 | | | 2:30 P |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Female | | White | | April 14, 1878 | | 90 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Virginia | | U.S.A. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY |
| Germantown | | | Box 263 | | | Housewife | | | home |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | Montgomery | | Germantown | | Box 263 | | | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| Robert Mahorney | | | Mary Hudson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| no | | none | | Mrs. Mary Benson | | 7100 Muncaster Mill Rd., Derwood, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>4270 Congestive Heart Failure.</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) <u>Terminal Pneumonia.</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-5-68</u> , 19 <u>68</u> , to <u>3-29</u> , 19 <u>69</u> , that (I) (we) lost
saw the deceased alive on <u>3-22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>L. P. Leal</u> | | | | | DEGREE ATTENDING
PHYS. <input checked="" type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3-31-69</u> | | |
| 22d. PHYSICIAN'S
NAME (Type) <u>L. P. Leal - M.D.</u> | | | | | 22e. ADDRESS
<u>Gaithersburg - Md</u> | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| burial | | 4-1-69 | | St. Mary's Cemetery | | Rockville, Maryland | | | |
| 24. FUNERAL DIRECTOR
ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| ROBERT A. PUMPHREY ROCKVILLE, MD. | | | | | DATE APR 7 1969 | | <u>J. Charles Judge</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The plates remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 04234 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04226 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Edith Mary Shannon</i> | | | 2a. DATE OF DEATH
<i>Mar 23 1969</i> | | | 2b. HOUR
<i>5:50 PM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
<i>June 14-1882</i> | | 6. AGE (In years
+ last birthday) <i>86</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign
country) <i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>US</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montg.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) <i>West Lane Hosp.</i> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY <i>Clerical</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Montg.</i> | | 13c. INSIDE CITY LIMITS? <i>Takoma Park</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>7300 Ballinow ave</i> | |
| 14. FATHER'S NAME First Middle Last
<i>James Preston Shannon</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Elizabeth Josephine Evans</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>577-12-7026A</i> | | 17. INFORMANT
<i>Eliz J Clark - 6306 W. 1st St, Pk SE</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Intestinal Pbt due to</i>
<i>5602</i> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Voluntary Cecum</i>
(b) <i>Shock</i> DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Shock</i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 day.</i>
<i>5 hrs.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 10, 1967</i> , to <i>3/23/1969</i> , that (I) (we) last saw the deceased alive on <i>3/23/1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>5:50 PM</i> | | | | | | | |
| 22b. SIGNATURE
<i>Howard J. Morse</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>3/23/69.</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>Howard J. Morse</i> | | | | 22e. ADDRESS
<i>7030 Carroll Ave Takoma Park Md</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>3-27-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Rock Creek</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Washington, D. C.</i> | |
| 24. FUNERAL DIRECTOR
<i>Warner C. Pumphrey, Inc.</i> | | | | ADDRESS
<i>8434 Ga. Ave. Silver Spring, Md.</i> | | 25a. REC'D BY REGISTRAR
<i>MAR 28 1969</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>William J. Jones</i> | | | |

RECEIVED 10-10-1960

04534

RECEIVED 10-10-1960

RECEIVED 10-10-1960

RECEIVED 10-10-1960

RECEIVED 10-10-1960

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item #6, Film 411 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | |
|--|-----------------------------|---|---|--|
| 1. DECEASED NAME
(Type and print)
04235 DONALD RAY SHEETS | | 2a. DATE KNOWN OF ESTI-DEATH MATED
<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year
3 26 69 | | 2b. HOUR
LP M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
12/14/42 | 6. AGE (In years, last birthday)
26 25 YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> |
| 7a. BIRTHPLACE (State or foreign country)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery Md. |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
sheet metal worker |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before address)
Silver Spring Md. | | 13b. CITY OR TOWN
SSMd. | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
11459 Lockwood Dr. SSMd. |
| 14. FATHER'S NAME
Carl Sheets | | 15. MOTHER'S MAIDEN NAME
Elizabeth Mc Intyre Cookerly | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
yes | | 16b. SOCIAL SECURITY NO.
517-406383 | | |
| 17. INFORMANT
wife Carol | | ADDRESS
11459 Lockwood Dr. SSMd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive aspiration of gastric contents
8120
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) due to auto accident
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
12:30 P.M. 3-26 1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1(a) or Part 2, item 18.)
Deceased, driving, collided with another vehicle. |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Street | | 21f. LOCATION Street or R.F.D. No. S. S. City or Town Montg. County Md. State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
3/26/1969 |
| EXAMINER'S NAME (Type)
BELDEN R. REAP, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county)
Ellicott City, Md. |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE
3-29-69 | 23c. NAME OF CEMETERY OR CREMATORY
Good Shepherd | 23d. LOCATION (City or Town) (County) (State)
Ellicott City Md | |
| 24. FUNERAL DIRECTOR
Higginbottom-Slack | | 25a. REC'D BY REGISTRAR
APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE
James H. Judge |

26530

2

1

1. *Chlorophyll a* (Chl *a*)

January 1998

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04236

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04228

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|---|---|---|--|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) John Henry SHULTZ | | | 2a. DATE OF DEATH
Month March Day 9 Year 69 | | | 2b. HOUR
1132 M | | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
Dec. 6, 1901 | | 6. AGE (In years last birthday)
67 YRS. | | IF UNDER 1 YEAR
MONTHS 3 DAYS 3 | | IF UNDER 24 HRS
HOURS 3 MIN | |
| 7a. BIRTHPLACE (State or foreign country)
West Indies | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
U. S. Navy | | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virgin Islands | | | 13b. CITY OR TOWN
St. Croix | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Box 1453, Christiansted St. | | | | |
| 14. FATHER'S NAME
First Paul Middle Theodore Last Shultz | | | 15. MOTHER'S MAIDEN NAME
First Emma Middle Pfiautz Last Pfiautz | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes | | | 16b. SOCIAL SECURITY NO.
1922-1952 | | 16c. 230 46 2124 | | 17. INFORMANT College Carlisle Address Penn.
Col. John M. Shultz, USA, Box 113, Army War | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stress ulcer-bleeding
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Renal tubular necrosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Villous adenoma, status post-operative | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Multiple pulmonary emboli | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 31 , 19 69 , to Mar. 9 , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Mar. 9 , 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Jack Ratliff | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Mar. 10, 1969 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Jack Ratliff, M. D. | | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, RITUAL (Specify)
Burial | | 23b. DATE
3-14-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia | | | | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Dunbar Funeral Home | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 14 1969 | | 25b. REGISTRAR'S SIGNATURE
William S. Judge | | | | |
| 7557 Wisconsin Ave., Bethesda, Md. | | | | | | | | | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Belden R. Reap (prop) will sign

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 04229 | | | | | | | |
|--|--|------------------|--|---|--|---|--|---|--|---|--|---|--|--|--|--|--|-----------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | | First
Reinhard | | | | Middle
Paul | | | | Last
Sieving | | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 3 6 1969 | | 2b. HOUR
7:25 P.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
6/5/04 | | 6. AGE (In years
last birthday)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month 3 Day 6 Year 1969 | | | | 2d. HOUR
7:25 P.M. | | | |
| 7a. BIRTHPLACE (State or foreign
country) Indiana | | | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery | | | | Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Holy Cross Hosp. | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Lutheran Minister | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Religious | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) State North Carolina | | | | 13b. CITY OR TOWN
Catawba | | | | 13c. CITY OR TOWN
Newton | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
130 Pinehurst Lane | | | | | | | |
| 14. FATHER'S NAME
First Middle Last
? Sieving | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
? | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | | (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
242 522 647 | | | | 17. INFORMANT
Bernice wife | | | | ADDRESS
same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | |
| (b) <u>Arteriosclerotic heart disease</u> | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
10/25/68 | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED?
Plastic Aortic Valve (Defective Aortic valve) | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type) | | | | Belden R. Reap M.D.
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | 22b. DATE SIGNED
March 7, 1969 | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | | 23b. DATE
Mar 10, 1969 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Newton Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Newton Catawba N C | | | | | | | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons Hyattsville, Md. | | | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 10 1969 | | | | 25b. REGISTRAR'S SIGNATURE
J Charles Judge | | | | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 411 Maryland State Department of Health
4-2-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04230

04238

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|--|---|--|---|--|---|---------------|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First
Charles | | | Middle
William | | | Last
Smith | | | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> Month Day Year
March 18 19 69 | | | 2b. HOUR
2:10 a.m. | | | | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
10-22-24 | | 6. AGE (In years last birthday)
44 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
3 Month 18 Day 69 Year 19 | | | 2d. HOUR
2:10 a.m. | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Sanitary Aid | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Health Dept. | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | 13b. COUNTY
Montgomery | | | | 13c. CITY OR TOWN
Olney | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
17415 Old Baltimore Rd. | | | | | | | |
| 14. FATHER'S NAME
First Middle Last
William Smith | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Margaret Martin | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)
yes WW II | | | | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
ADDRESS
Montgomery Gen. Hospital Records Olney, Md | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhagic pneumonitis, diffuse, bilateral
485X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 22b. DATE SIGNED
3/18/1969 | | | | | | | |
| EXAMINER'S NAME (Type)
BELDEN R. REAP M.D. | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | ADDRESS (Street, city, town or county)
Sandy Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE
3-22-69 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Sharp Street Church | | | | 23d. LOCATION (City or town) (County) (State)
Sandy Spring, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
Robert L. Snowden | | | | | | ADDRESS
Rockville, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE
MAR 21 1969 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

CLEARED BY BELDON REAP, M.D. (CORONER)
2:30 PM 3/26/69

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04239

CERTIFICATE OF DEATH

04231

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) <u>First</u> <u>EVA</u> <u>Middle</u> <u>J.</u> <u>Last</u> <u>Smith</u> | | | 2a. DATE OF DEATH
<u>3</u> Month <u>26</u> Day <u>69</u> Year | | 2b. HOUR
<u>1:40</u> PM |
| 3. SEX
<u>FEMALE</u> | 4. RACE
<u>WHITE</u> | 5. DATE OF BIRTH
<u>3/21/89</u> | | 6. AGE (In years last birthday)
<u>80</u> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
<u>Minnesota</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>MONTGOMERY</u> Md. | |
| 10. CITY OR TOWN OF DEATH
<u>SILVER SPRING</u> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>HOLY CROSS</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>HOUSEWIFE</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
— |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>M.D.</u> | | 13b. COUNTY
<u>MONTGOMERY</u> | 13c. CITY OR TOWN
<u>Silver Spring</u> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<u>1908 GLEN ROSS ROAD</u> |
| 14. FATHER'S NAME
<u>(unknown)</u> | | 15. MOTHER'S MAIDEN NAME
<u>(Unknown)</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or unknown) <u>No</u> (If yes give war or dates of service) | |
| 16b. SOCIAL SECURITY NO.
<u>215-48-6090</u> | | 17. INFORMANT
<u>Silver Spring, Md.</u>
<u>Rev. Wm. R. Wooten, Jr. 1607 Grace Church Rd.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u>
<u>4339</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>CEREBRAL ATHEROSCLEROSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>17 DAYS</u>
<u>1 YEAR</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>ARITMULAR FIBRILLATION</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 9, 1955</u> , to <u>MARCH 26, 1969</u> , that (I) (we) last saw the deceased alive on <u>3/26</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>James A. Roberts</u> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3/26/69</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>JAMES A. ROBERTS</u> | | 22e. ADDRESS
<u>8907 GEORGIA AVE. SILVER SPRING, MD.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>April 2, 1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Prospect Hill Cemetery</u> | |
| 23d. LOCATION (City or Town) (County) (State)
<u>Washington, D.C.</u> | | | | | |
| 24. FUNERAL DIRECTOR
<u>Warner E. Humphrey, Inc. Silver Spring, Md.</u> | | 25. REC'D BY REGISTRAR
<u>APR 3 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>John Charles Judge</u> | |

08230

088.2.1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04240

CERTIFICATE OF DEATH

04232

| | | | |
|--|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>9606 Cable Dr.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Francis E. Smith</u> | | 4. DATE OF DEATH <u>3-15-69</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-28-92</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Francis E. Smith</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna T. Stack</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WAR I</u> | | 16. SOCIAL SECURITY NO. <u>578 03 8693</u> | |
| 17. INFORMANT <u>Lenore Smith</u> | | Address <u>Same as #2</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Heart failure</u>
DUE TO (b) <u>Diabetes Mellitus</u>
DUE TO (c) <u>Generalized arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>2 years</u>
<u>3 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>64</u> , to <u>3/15</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/15</u> , 19 <u>69</u> , and that death occurred at <u>7P</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John E. Everett</u> | | 22b. DATE SIGNED <u>3/15/69</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u> | | 22d. ADDRESS <u>9400 Conn. Ave. Kensington</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>3-19-69</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Mont. Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Francis J. Collins</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE | | DATE <u>MAR 20 1969</u> | |

06940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|---|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 04241 | | | | | 04233 | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| Marie Josephine Smith | | | | | Month March Day 30 Year 1969 | | | 5:15 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | |
| Female | | White | | 7 August 1945 | | | 23 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Washington, D.C. | | U.S.A. | | | | Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | The Clinical Center, NIH | | | Telephone Service Rep. | | | unemployed | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Prince Georges | | Hyattsville | | YES | | 4818 Glenoak Road | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Albert H. Di Tizio | | | Marjorie Saarikoski | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | |
| no | | | 217-44-6938 | | The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland 20014 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease (Extensive tumor of the viscera) | | | | | | | | | | 4 year | |
| 201X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (X) (this hospital) attended the deceased from 13 February 1969, to 30 March, 1969, that (X) (we) lost saw the deceased alive on 30 March 1969, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| David A. Bray | | | | | | | | 30 March 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | David A. Bray, MD. | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 4/3/69 | | Ft. Lincoln Cem. | | Colmar Manor, Md. | | | | | |
| 24. FUNERAL DIRECTOR Valley's Funeral Home Inc. | | | | ADDRESS Mt. Rainier, Maryland | | 25a. REC'D BY REGISTRAR DATE APR 7 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

00254

OFFICE OF THE SECRETARY OF DEFENSE

MEMORANDUM FOR THE SECRETARY OF DEFENSE
SUBJECT: [Illegible]
DATE: [Illegible]
FROM: [Illegible]
TO: [Illegible]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page.]

APR 1 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|--|--|--|--------|---|------|--|--|--|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | |
| William Horace Smith | | | | | | | | | 3 23 69 | | | 5:45 AM | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | 7. IF UNDER 1 YEAR
MONTHS DAYS | |
| Male | | | White | | | 8-20-10 | | | 58 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| Mississippi | | | U.S.A. | | | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Silver Spring | | | Holy Cross Hosp. | | | Statistician | | | Gov't. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | |
| Md. | | | Montgomery | | | Sil. Spr. | | | YES | | | 12102 Bushey Drive | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| Albert Poole Smith | | | Mattie Biggs | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | |
| Yes | | | W.W. II | | | Sammie W. Smith - 12102 Bushey Dr. S.S. Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION | | | | | | | | | | | SUDDEN | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE, DECOMPENSATED | | | | | | | | | | | 5 YEARS | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION AND ARTERIOSCLEROSIS | | | | | | | | | | | 10 YEARS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| PULMONARY CARCINOMA, HEPATIC FAILURE, CIRRHOSIS | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 1959, to MARCH 21, 1969, that (I) (we) last saw the deceased alive on 3/21/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
A. Earl Vivino, MD | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
3/23/69 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
A. EARL VIVINO, MD | | | | | | 22e. ADDRESS
2500 WISCONSIN AVE NW | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | March 26, 1969 | | | Lakewood Cemetery | | | Jackson, Mississippi | | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. Silver Spring, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 28 1969 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | |

MEDICAL CERTIFICATION

5530250

0201015013

Figure 2

✕

EARL VINO, MD

344 442 400 210 602 C

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 04243 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04235 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
<i>Fred Smithies</i> | | | 2a. DATE OF DEATH
Month Day Year
<i>March 12 1969</i> | | | 2b. HOUR
<i>1045 AM</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>May 27, 1894</i> | | 6. AGE (In years last birthday)
<i>74</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Mass</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Holy Cross</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Barber Supt.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Dist. Govt.</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Wheaton</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
<i>George Smithies</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Unknown</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
<i>yes</i> | | 16b. SOCIAL SECURITY NO.
<i>577-09-6933-A</i> | | 17. INFORMANT
<i>Mrs. Elva C. Smithies</i> | | | |
| | | | | 22a. ADDRESS
<i>2210 Henderson Ave., Wheaton, Maryland</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Myocardial Infarction</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Generalized Atherosclerosis</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i>
<i>2 days</i>
<i>years</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/10/69</i> , to <i>3/12/69</i> , that (I) (we) last saw the deceased alive on <i>3/12/69</i> , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>John J. Curry MD</i> | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>3/13/69</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>John J. Curry</i> | | | | 22e. ADDRESS
<i>9801- Georgia Avenue Silver Spring, Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>March 15, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Lincoln Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Bladensburg, Maryland</i> | |
| 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc.</i> | | | | 25a. REC'D BY REGISTRAR
DATE
<i>MAR 19 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. Jones</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 04244 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04236 | |
|---|--|--|---|--|--|---|--|--|---|---|--|--|--|--|-------------------------------|--|--|--|--|----------|--|
| 1. DECEASED-NAME
(Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | |
| Mary VIRGINA Sorrell | | | | | | | | | | Month 3 Day 19 Year 69 | | | | | | | | | | 1:40 P M | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
Jan 29 1885 | | | 6. AGE (In years last birthday)
84 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | IF UNDER 24 HRS.
HOURS MIN | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Wash DC | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Kensington | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Kensington Gardens Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY
At Home | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Silver Spring | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
1520 Jasper St Silver Spring | | | | | | | | | |
| 14. FATHER'S NAME
Cyrus M Allen | | | 15. MOTHER'S/MAIDEN NAME
Lillis Ella Moulden | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or (unknown) (If yes give war or dates of service)
NO | | | 16b. SOCIAL SECURITY NO.
220-54-0457N | | | 17. INFORMANT
Ethel B Stephens Rt 2 Watersville Rd Mt Airy Md | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral vascular disease</u>
4370 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 yrs | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)
<u>Essential hypertension & bronchial asthma</u> | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/29, 1966, to 3/19, 1969, that (I) (we) last saw the deceased alive on 3/18, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
H F Kreuzburg MD | | | 22c. DATE SIGNED
3/19/69 | | | 22d. PHYSICIAN'S NAME (Type)
H F Kreuzburg | | | | | | | | | | | | | | | |
| 22e. ADDRESS
7852 16th NW Wash DC | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
3-22-69 | | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Zion Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Bethesda, Mont Md | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Robert A Pumphrey | | | ADDRESS
7557 Wisconsin Ave Bethesda, Md | | | 25a. REC'D BY REGISTRAR
MAR 24 1969 | | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | | | | | | | | | | | | |

44244



[Faint, illegible handwriting on lined paper]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|
| 04245 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04237 | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Helen S. SOWERS | | | | | | 2a. DATE OF DEATH Month Day Year
March 20- 69 | | 2b. HOUR A
5:20 M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
10/9/1882 | | 6. AGE (In years lost birthday)
86 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Michigan | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Wheaton Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
11008 Glueck Lane | |
| 14. FATHER'S NAME First Middle Last
Smith Henry J. | | 15. MOTHER'S MAIDEN NAME First Middle Last
Helen Adelia Moulton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO.
521-48-2738 | | 17. INFORMANT Address
Don C. Sowers, Jr. (son) 11008 Glueck Lane | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4379 Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain Stem Stroke
DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Arteriosclerosis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1965, to March 20, 1969, that (I) (we) saw the deceased alive on March 19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert T. Thibadeau | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-20-69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Robert T. Thibadeau | | | | 22e. ADDRESS
11000 Old Georgetown Rd., Rockville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/22/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Spring Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Spring Hill, Kansas | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. Silver Spring, Maryland | | | | 25a. REC'D BY REGISTRAR
MAR 24 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

04347

MINUTE OF DEATH

MINUTE OF DEATH

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04246

04238

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | |
|--|----------------------|--|--|---|
| 1. DECEASED-NAME
(Type or Print) <i>Eleanor</i> First Middle Last <i>CAREY Spellman</i> | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <i>March 1 1969</i> | | 2b. HOUR <i>PP M</i> |
| 3. SEX <i>FEMALE</i> | 4. RACE <i>WHITE</i> | 5. DATE OF BIRTH <i>July 12, 1910</i> | 6. AGE (In years last birthday) <i>58</i> YRS. | 7. IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> |
| 7a. BIRTHPLACE (State or foreign country) <i>New York</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH <i>Cherry Chase.</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>3501 Turner Lane</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Secretary</i> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Bethesda</i> |
| 14. FATHER'S NAME First Middle Last <i>Herbert A. Carey</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Lila</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> |
| 16b. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT <i>13006 - Hawthorne St. Silver Spring, Md. Lawrence W. Spellman</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Shock & Asphyxia</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Burns - 2nd + 3rd degree - Over 80% of Body</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>890X</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year <i>7 P.M. 3/1/1969</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fell asleep on couch smoking cigarette -</i> |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home -</i> | | 21f. LOCATION Street or R.F. No. City or Town County State <i>3501 Turner Lane Cherry Chase Montgomery Md.</i> |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED <i>March 3, 1969</i> |
| EXAMINER'S NAME (Type) <i>JOHN G. BALL, MD.</i> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, county, state) <i>Montgomery Co. Maryland.</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>3-5-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i> |
| 23d. LOCATION (City or Town) <i>Rockville, Montg. Co. Md.</i> | | 23e. REC'D BY REGISTRAR <i>MAR 6 1969</i> | | 23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |
| 24. FUNERAL DIRECTOR <i>7557 Wisconsin Ave. Bethesda, Maryland. ROBERT A. PUMPHREY</i> | | | | |

92520

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|--|--|--|---|--|---|---|--|
| <div>04247</div> <div>04239</div> | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| CAMILIA | | | Nielsen Starr | | | <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year
OF ESTI- MATED 3 11 1969 | | P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Fe. | W. | Jan 6, 1920 | 49 YRS. | MONTHS DAYS | HOURS MIN. | Month March 13 Year 1969 | | 12 AM | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| New York | | U.S.A. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cherry Chase. | | | 7701 Meadow Lane. | | | None | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md. | | | Montgomery | | | Cherry Chase | | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Hans Nielsen | | | UNKNOWN. | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| | | | | | | Philippa T. Starr AS ABOVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia</u>
<u>9502</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>overdose of Drugs Tranquilizers & Hypnotics 1/2 hr.?</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | HOUR <u>4</u> P.M. <u>3 11</u> 1969 | | Took overdose of Nodulin, Elonal, Somnux. | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | Home | | 7701 Meadow Lane | | Cherry Chase | | Montgomery Md. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | March 13, 1969. | | | |
| John G. Ball | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 7936 Old Gertown | | | |
| | | | ADDRESS (Street, city, town, or county) | | | Bethesda Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Burial | | 3-15-69 | | Parklawn Cemetery | | Rockville Pr. | | Geo Md | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert A. Pumphrey 7557 Wisconsin Ave Bethesda, Md | | | | MAR 19 1969 | | | | | |

04347

STATE OF TEXAS

COUNTY OF DALLAS

04347

STATE OF TEXAS
COUNTY OF DALLAS

5-10-1911

NOTARIAL PUBLIC

My commission expires

on

the

day of

1911

at

the City of

Dallas

County of Dallas

State of Texas

before me

on

the

day of

1911

at

the City of

Dallas

County of Dallas

State of Texas

before me

on

the

day of

1911

at

the City of

Dallas

County of Dallas

State of Texas

before me

on

the

day of

1911

at

the City of

Dallas

County of Dallas

State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|--|--|---------------------------------|--|-----------------------------------|-------------------|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Victor | | M. | | Stephans. | | Month Day Year
3-22-69 | | | 11:00 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| Male | | White | | 4-9-04 | | | 64 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Harbin Manchuria | | U.S.A. | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | Suburban | | | | Distributor | | | Auto Tires | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | Montgomery | | Bethesda | | YES | | 5948 Avon Drive | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| Michael | | T. | | Stephans. | | | | MATRONA | | - SCHEKERENK | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| No | | | | Helen Stephens | | 5948 Avon Drive | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Hemorrhage | | | | | | | | | | | |
| 4319 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Arterio Sclerosis | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan, 1964, to Jan, 1969, that (I) (we) last saw the deceased alive on Jan 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | | |
| W. A. Killay M.D. | | 3-23-69 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| Wm. H. Killay | | 8218 W. Ave. Bethesda, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 3-26-69 | | Rock Creek Cem. | | Washington, D.C. | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Jas. Stawler | | MAR 26 1969 | | Charles Jones | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|---|---|---|--|-----------------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 04249 | | | | | 04241 | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| First Middle Last
Maurice William Stevenson | | | | | 3 Month 12 Day 69 Year | | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Male | | Negro | | 12/12/09 | | 59 YRS. | | IF UNDER 24 MRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Washington, D.C. | | USA | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Wheaton | | | University Nursing Home | | | Dishwasher | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| D.C. | | | 3b. COUNTY | | Washington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1413 1st Street | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last
William Henry Stevenson | | | First Middle Last
Edna Daleman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | | 579-10-7884 | | Lorris Stephenson 22 Todd Pl NE Wash D.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) cerebrovascular occlusion | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) arteriosclerotic cerebrovascular disease | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) disease | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 28 Jan, 1969, to 12 Mar, 1969, that (I) (we) last saw the deceased alive on 11 March 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | 22c. DATE SIGNED | | | | | |
| Walter Boogh MD | | | | | 12 March 69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | |
| Walter Boogh | | | | | 2390 Ringwood Cir. Wheaton Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 3-17-69 | | Hammern Cemetery | | Baltimore County Md | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| John D. Watson, Watson's Funeral Home | | | | | MAR 13 1969 | | Charles Judge | | | |

RECEIVED

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04250

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|--|---|---|--|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Nancy Carol Stolzenberger | | | 2a. DATE OF DEATH
Month Day Year
March 7 1969 | | | 2b. HOUR P
9:00M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
31 March 1946 | | 6. AGE (In years
lost birthday)
22 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
The Clinical Center | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Sec-Stenographer | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before
admission) STATE
New Jersey | | 13b. COUNTY
1 | | 13c. CITY OR TOWN
Irvington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
21 Allen Street | |
| 14. FATHER'S NAME First Middle Last
Martin Stolzenberger | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Helen Reichardt | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
156-36-6878 | | 17. INFORMANT The Medical Records Address
The Clinical Center, NIH, Bethesda, Md. 20014 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hodgkin's Disease involving liver/lymph nodes</u>
<u>201X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Hemorrhage of wall of cecum/surrounding tissues</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u>
<u>12 hours</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that IX this hospital attended the deceased from <u>17 Jan.</u> , 19 <u>69</u> , to <u>7 March</u> , 19 <u>69</u> , that IX (we) last saw the deceased alive on <u>7 March</u> , 19 <u>69</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, IX (we) (did) (not see) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Clarence H. Brown, III, M.D.</u> DEGREE | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>3-7-69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
Clarence H. Brown, III, M.D. | | | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-12-69 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Peters Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Garfield, New Jersey | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE
MAR 12 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>William J. Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04250

STATE OF TEXAS

County of _____ State of Texas

Know all men by these presents, that _____ of the County of _____ State of Texas

do hereby certify that _____ of the County of _____ State of Texas

is the owner of the following described land to-wit:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515
45M - 11/69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|------------------------------|--|------------------|---|---------------|---|---------------------------------|--|--|----------|-------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| INFANT GIRL STREET | | | | | | | | | 3 Month 11 Day 69 Year | | 140p M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | | WHITE | | 3/11/69 | | | | | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | WIDOWED | | DIVORCED | | MONTGOMERY | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BETHESDA | | | SUBURBAN HOSPITAL | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | |
| Maryland | | | MONTGOMERY | | WHEATON | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 12304 CHARLES Rd. | | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | |
| DELMAR | | | | | | | STREET | | WANDA | | | MANIS | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | | |
| Yes, no, or (unknown) | | | | | FATHER | | SAFE | | | | | | |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) PULMONARY ATELECTASIS | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | |
| (b) IMMATURITY | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/11, 1969, to 3/11, 1969, that (I) (we) last saw the deceased alive on 3/11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | | |
| Joseph F. McKelvie MD | | | 3/11/69 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | |
| | | | | | | | | | | | | | |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| | | | 3/14/69 | | Suburban Hospital | | Bethesda - Montg. - MD | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| Mrs. Amelia C. Carter, Administrator | | | MAR 17 1969 | | V. L. Lewis, Registrar | | | | | | | | |

04320

RECORD OF DEEDS

04320

THIS BOOK CONTAINS RECORDS OF DEEDS FOR THE YEAR 1900

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[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Released by Med Examiner, Dr. Keap

04252

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04244

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print)
First Middle Last
ROBERT D. STUTZEL | | | 2a. DATE OF DEATH
Month Day Year
3 24 69 | | | 2b. HOUR
7:10 A | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
2/17/69 | | 6. AGE (In years last birthday)
2 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
minor | | 12b. KIND OF BUSINESS OR INDUSTRY
none | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Prince Georges | | 13c. CITY OR TOWN
Beltsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
11380 Cherry Hill Rd. | |
| 14. FATHER'S NAME
First Middle Last
Dennis Stutzel | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Pamela ? Hunt | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
none | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Address
father Dennis 11380 Cherry Hill Rd. Beltsville | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 484X Fever of unknown origin
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable Interstitial pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/17, 1967, to 3/24, 1969, that (I) (we) last saw the deceased alive on Not Recently, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Ralph Stiller M.D. | | | | DEGREE
ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | | 22c. DATE SIGNED
March 24, 1969 | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Ralph Stiller | | | | 22e. ADDRESS
1110 Spring Street Silver Spring Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Mar. 27, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Elmwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Dewitt Clinton Iowa | | | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAR 27 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

32530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04253

04245

| | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) JAMES LEO SULLIVAN | | | 2a. DATE OF DEATH
Month 3 - Day 24 - Year 1969 | | | 2b. HOUR
5:00 AM | | | | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
10/18/184 | | 6. AGE (In years last birthday)
84 YRS. | | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS.
HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
N.Y. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Randolph Hills Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
RETIRED - PRINTER | | | 12b. KIND OF BUSINESS OR INDUSTRY
NEWSPAPERS | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C. | | | 13b. COUNTY D.C. | | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4700 14th St. N.W. | | | | | |
| 14. FATHER'S NAME
First MICHAEL Middle SULLIVAN Last SULLIVAN | | | 15. MOTHER'S MAIDEN NAME
First MRS. ETELKA M. SULLIVAN Middle WIDOW Last WIDOW | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO.
578-09-9442 | | 17. INFORMANT
Address JAME AS #13
MRS. ETELKA M. SULLIVAN, WIDOW | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT (MULTIPLE)
DUE TO, OR AS A CONSEQUENCE OF
(b) GENERALIZED ATHEROSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) HYPERTENSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
AUG 69 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
PROSTATISM & URINARY RETENTION & INFECTION | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
NOX | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
NOX | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug , 1968, to 3/24 , 1969, that (I) (we) last saw the deceased alive on 3/9 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Robert L. Flynn MD DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
3/24/69 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT L. FLYNN MD | | | | | | 22e. ADDRESS
916 19th St NW Wash DC | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
3-26-1969 | | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Olivet Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS Wash., D.C.
Joe. Stauler's Sons 5130 Macaw NW | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 26 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

042220

OFFICE OF THE

Washington, D.C.

James Oliver Cemetery

-28-1009

Serial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04254

04246

| | | | | | | | | | | |
|--|--|--|--|--|------|---|---|---|-----------------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Infant Boy | | | | | | March 14 1969 | | | 6 ³⁵ PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Male | | White | | March 14, 1969 | | YRS. | | MONTHS | DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | | United States | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | | Holy Cross | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Maryland | | | Prince George Hyattsville | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 2013 Oglethorpe Street | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Lost | | | First Middle Lost | | | | | | | |
| Michael Kern Sweeney | | | Janet mae Bryant | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | |
| | | | | | | Mother | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Prematurity (6 mos gestation) | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year P.M. | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED |
| Joseph A. Dugan, M.D. | | | | | | | | | | 3-14-69 |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | |
| Joseph A. Dugan, M.D. | | | | | | 500 Edmonston Dr. Rockville, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3/20/69 | | Gate of Heaven Cemetery | | | Silver Spring, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Tyson Wheeler | | | | | | MAR 26 1969 | | Thomas Judge | | |

03534

03534

PI March 14 1968

March 14 1968

Montgomery

Silver Spring

Montgomery Prince Georges Hospital

Michael

Michael

Left 6:15 PM

Left 6:15 PM

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04255

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04247

| | | | | | | | | |
|---|-------------------|--|---|---|---|--|--|---|
| 1. DECEASED-NAME
(Type or Print) <u>Grace Margaret Sweitzer</u> | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> <u>March 22 1969</u> | | | 2b. HOUR <u>7:30 A.M.</u> | | |
| 3. SEX <u>Fe.</u> | 4. RACE <u>W.</u> | 5. DATE OF BIRTH <u>Jan. 31 1882</u> | 6. AGE (In years last birthday) <u>87</u> YRS. | IF UNDER 1 YEAR
MONTHS <u> </u> DAYS <u> </u> | IF UNDER 24 HRS.
HOURS <u> </u> MIN. <u> </u> | 2c. DATE PRONOUNCED DEAD
Month <u>March</u> Day <u>22</u> Year <u>1969</u> | | |
| 7a. BIRTHPLACE (State or foreign country) <u>Penna.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Montgomery</u> Md. | | |
| 10. CITY OR TOWN OF DEATH <u>Damascus</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>9313 Gue. Rd.</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>HOUSEWIFE</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u> | | | 13b. COUNTY <u>Montgomery</u> | | 13c. CITY OR TOWN <u>Damascus</u> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER <u>9313 Gue. Rd.</u> | |
| 14. FATHER'S NAME First <u>Daniel</u> Middle <u>W.</u> Last <u>Bretzman</u> | | | 15. MOTHER'S MAIDEN NAME First <u>SARAH</u> Middle <u>MARTHA</u> Last <u>HYSON</u> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | |
| 16b. SOCIAL SECURITY NO. <u>220-44-9241</u> | | | 17. INFORMANT <u>daughter - Evelyn Sweitzer Fite</u> ADDRESS <u>same</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute -</u>
<u>4124</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Cardiovascular Disease -</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u> </u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u>
<u>years.</u> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <u> </u> P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. <u> </u> | | City or Town <u> </u> | | County <u> </u> State <u> </u> |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <u>March 22, 1969</u> | | |
| EXAMINER'S NAME (Type) <u>John G. Ball</u> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) <u> </u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>3/25/69</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Stewartstown Cem.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Stewartstown, York Co., Pa.</u> | | 23e. REC'D BY REGISTRAR <u>MAR 26 1969</u> |
| 24. FUNERAL DIRECTOR <u>Bennett W. Ashburn</u> | | | | ADDRESS <u>Stewartstown, Pa.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

04322



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 411 MARYLAND STATE DEPARTMENT OF HEALTH
4-3-69 ans DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04248

Item #6, Film G110 3/21 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | |
|---|-----------------------------|---|--|--|
| 1. DECEASED NAME
First Middle Last
DELLA M THOMAS | | 2a. DATE KNOWN OF DEATH
Month Day Year
3 15 1969 | | 2b. HOUR
7:20 A.M. |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
9-4-87 | 6. AGE (In years last birthday)
81 YRS | 7. COUNTRY OF BIRTH
U.S.A. |
| 7a. BIRTHPLACE (State or foreign country)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. COUNTY OF DEATH
MONTGOMERY | | 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLY CROSS HOSP. |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. |
| 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SP. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET AND NUMBER
10100 QUINBY ST | | 14. FATHER'S NAME
First Middle Last
ANDREW HAILSLIP | | 15. MOTHER'S MAIDEN NAME
First Middle Last
SARAH CHURCH |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
NO | | 16b. SOCIAL SECURITY NO.
WA-258975 | | 17. INFORMANT
ADDRESS
10100 QUINBY ST.
SILVER SP. MD. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral infarction;
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral arteriosclerosis, severe
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE
Belden R. Keap | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
3/15/1969 |
| EXAMINER'S NAME (Type)
BELDEN R. KEAP M.D. | | ADDRESS (Street, City, Town, or County)
4339 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE
March 18, 1969 | 23c. NAME OF CEMETERY OR CREMATORY
M.T. HOPE | 23d. LOCATION (City or Town) (County) (State)
EAST ST. LOUIS ILLINOIS | 24. FUNERAL DIRECTOR
Warner E. Pumphrey
PUMPHREY FUNERAL HOME
8434 Ga. Ave.
Silver Spring, Md. |
| 25a. REC'D BY REGISTRAR
DATE MAR 20 1969 | | 25b. REGISTRAR'S SIGNATURE
James J. Judge | | |

04826

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04258

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04249
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
<i>Dorsey L Thompson</i> | | | 2a. DATE OF DEATH
Month Day Year
<i>March 19 1969</i> | | | 2b. HOUR
M
<i></i> | | | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>Nov. 30, 1880</i> | | 6. AGE (In years last birthday)
<i>88</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
<i></i> | | IF UNDER 24 HRS
HOURS MIN.
<i></i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | | | | Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Wheaton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>1916 University Blvd. W.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Retired - Farmer</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i></i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. CITY OR TOWN
<i>Montgomery</i> | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER
<i>1916 University Blvd., West</i> | | | | | |
| 14. FATHER'S NAME
First Middle Last
<i>Millard Thompson</i> | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Julia Duwall</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <i>no</i> | | 16b. SOCIAL SECURITY NO.
<i>yes</i> | | 17. INFORMANT
Address <i>Wheaton, Md.</i>
<i>Mrs. James Brown, 1916 University Blvd., West</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Probable myocardial infarction</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>ascrtd.</i>
(b) <i></i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i></i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Severe Cirrhosis & Ascaris</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i></i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i></i> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i></i> | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
<i></i> P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<i></i> | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
<i></i> | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
<i></i> | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>March 19 1969</i> , to <i>March 19 1969</i> , that (I) (we) last saw the deceased alive on <i>Mar. 19 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>R. Bufalino</i> | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>Mar. 19 1969</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Russell Bufalino</i> | | | | 22e. ADDRESS
<i>1429 University Blvd. West, Silver Spring</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>March 22, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. John's Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Forest Glen, Mont., Maryland</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc.</i> | | | | ADDRESS
<i>8434 Georgia Avenue</i> | | 25a. REC'D BY REGISTRAR
DATE
<i>MAR 24 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Young</i> | | | |

04228

REPORT OF DEATH

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04250

04257

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | |
|--|---------|--|-------------------|--|---|---|-------|---|-------|--|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | Month | Day | Year | 2b. HOUR |
| James E Thompson | | | | | MATED <input checked="" type="checkbox"/> 3 16 1969 | | | | | 4:45 M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR |
| M. | W. | Oct. 8, 1915 | 53 YRS. | MONTHS | DAYS | HOURS | MIN. | Month | Day | Year |
| | | | | | | | | March | 16 | 1969 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | | U.S.A. | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Bethesda | | 5917 Ralston Rd. | | Restaurant | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Md. | | Montgomery | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5917 Ralston Rd. | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| Edward | | | Howard | Thompson | Julia Frances | | | | Owens | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | Same as Item 13. | | |
| Yes | | WW 11 | | 577-26-9678 | | Brother George Al Thompson | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Coronary Thrombosis - Acute - | | | | | | | | | | 30 days. |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| (b) Coronary Arteriosclerosis - | | | | | | | | | | years. |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| CAUSE OF DEATH | | HOUR A.M. P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | JOHN G. BALL | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) | | Bethesda, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 3-19-69 | | Baltimore Natl Cem. | | Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | MAR 24 1969 | | Charles Judge | | |

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RECEIVED TO THE DIRECTOR OF THE MEDICAL TRAINING CENTER OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|-----------------------------------|--|-------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| 04259 | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Beulah Edna Tilley | | | | | | 2a. DATE OF DEATH
Month Day Year
March 11 1969 | | | 2b. HOUR A
6:05 M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
1 December 1908 | | | 6. AGE (In years lost birthday)
60 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
North Carolina | | | | 13b. COUNTY
Vb. COUNTY | | 13c. CITY OR TOWN
Kernersville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Route # 6 | | |
| 14. FATHER'S NAME First Middle Last
William A. Ashley | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Eva Baines | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
Not Available | | 17. INFORMANT Bethesda, Maryland 20014
The Medical Records, The Clinical Center, | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cryptococcal Meningitis
1160
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 Months | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 25 January, 1969, to 11 March, 1969, that (X) (we) last saw the deceased alive on 11 March 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Robert R. Rich, M.D. | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
11 March 1969 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Robert R. Rich, M. D. | | | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
3-13-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Garden of Memory | | | 23d. LOCATION (City or Town) (County) (State)
Walkerstown N. C. | | | | | |
| 24. FUNERAL DIRECTOR
Robert A Pumphrey 7557 Wisc.Ave Beth, | | | | | | 25a. REC'D BY REGISTRAR
MAR 14 1969 | | 25b. REGISTRAR'S SIGNATURE | | | | |

04350

OFFICE OF DEATH

REPORT OF DEATH

Report of Physician 7557
Date of Death 1-15-50
Place of Death
Cause of Death
Manner of Death
Signature of Physician
Signature of Coroner
Signature of Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04260

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04252

CERTIFICATE OF DEATH

| | | | | | |
|--|-----------------------------|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) LOUISE First H. Middle TISDALE Last | | | 2a. DATE OF DEATH
Month 3 Day 11 Year 69 | | 2b. HOUR
5:05 PM |
| 3. SEX
Female | 4. RACE
CAUCASION | | 5. DATE OF BIRTH
11-19-1872 | | 6. AGE (In years
lost birthday)
96 YRS. |
| 7a. BIRTHPLACE (State or foreign
country) ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
MONTGOMERY | | Md. | | | |
| 10. CITY OR TOWN OF DEATH
CHEVY CHASE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital,
give street address) BETHESDA-SILVER SPRING
NURSING HOME | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
TEACHER | |
| 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MD/D.C. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Washington | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 5324
Wapakoneta Rd Wash. DC | | | |
| 14. FATHER'S NAME First FREDERICK Middle HEIDENRICK Last | | | 15. MOTHER'S MAIDEN NAME First ANNA Middle MEYERHOLZ Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, <u>no</u> , or (unknown) | | | 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
ROSA D Tisdale Address 5324 Wapakoneta Rd Wash DC |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4329 Thrombosis Middle cerebral artery
DUE TO, OR AS A CONSEQUENCE OF
(b) arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1907 , 19____, to____, 19____, that (I) (we) last
saw the deceased alive on MARCH 8 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Edward W. Youngblood, M.D. DEGREE | | 22c. DATE SIGNED
March 11, 1967 | | 22d. ADDRESS
Washington & Chevy Chase, D.C. | |
| 22e. PHYSICIAN'S
NAME (Type) Edward W Youngblood | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
3-15-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Township | |
| 23d. LOCATION (City or Town)
Zearing | | (County)
Iowa | | (State)
Iowa | |
| 24. FUNERAL DIRECTOR
Robert A Pumphrey Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
MAR 14 1969 | | 25b. REGISTRAR'S SIGNATURE
Robert A. Judge | |

000000

STATE OF TEXAS

COUNTY OF DALLAS

1900

1901

1902

1903

1904

1905

1906

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04261

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04253

| | | | | | | | | | | | | |
|---|--|---|--|--|---|---|--|---|--|-------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Bessie Edith Trainer | | | 2a. DATE OF DEATH
Month Day Year
March 4 1969 | | | 2b. HOUR
M | | | | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
4-13-85 | | 6. AGE (in years last birthday)
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 NRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
Amer | | 8. MARRIED
WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San E Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sandy Springs | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
17401 Norwood Road. | | | | |
| 14. FATHER'S NAME
First Middle Last
Joseph Ward | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Margaret Frazier | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
NO | | | | | | |
| 16b. SOCIAL SECURITY NO.
Unknown | | | 17. INFORMANT
Hospital Record | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the bladder</u>
1888X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>hemorrhage from bladder</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , to <u>3-4</u> , 1969, that (I) (we) last saw the deceased alive on <u>3-3</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
M Snow M.D. | | | | | | DEGREE
ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-4-69 | | |
| 22d. PHYSICIAN'S NAME (Type)
M. SNOW MD | | | | | | 22e. ADDRESS
9013 Flower Ave Silver Spring | | | | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify)
Burial | | | 23b. DATE
Mar 7, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Memorial Park | | | 23d. LOCATION (City or Town) (County) (State)
Whitell Turnship Prince Georges | | | | |
| 24. FUNERAL DIRECTOR
James H. Moore | | | ADDRESS
254 Carroll St. N.W. Washington, D.C. 20012 | | | 25a. REC'D BY REGISTRAR
DATE MAR 7 1969 | | | 25b. REGISTRAR'S SIGNATURE
James H. Moore | | | |

10930

RECEIVED

10930

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04262

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04254

| | | | | | | | | |
|--|----------------------|--|---|---|---|---|---|--|
| 1. DECEASED-NAME
(Type or Print) <i>Lucille S. Turman</i> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>March</i> Day <i>23</i> Year <i>1969</i> | | | 2b. HOUR <i>4:30</i> M. | | |
| 3. SEX <i>F</i> | 4. RACE <i>Negro</i> | 5. DATE OF BIRTH <i>3/14/32</i> | 6. AGE (In years last birthday) <i>37</i> YRS. | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | IF UNDER 24 HRS.
HOURS <i></i> MIN. <i></i> | 2c. DATE PRONOUNCED DEAD
Month <i>March</i> Day <i>23</i> Year <i>1969</i> | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Mont.</i> | | 13c. CITY OR TOWN <i>Poolesville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>Route 28</i> |
| 14. FATHER'S NAME First <i>John I.</i> Middle <i></i> Last <i>Senior</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Marion</i> Middle <i></i> Last <i>Hale</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT <i>John I. Senior</i> | | ADDRESS <i>Same as above (John)</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute pancreatitis</i>
<i>5770</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 weeks</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Fatty cirrhosis of liver (chronic alcoholism)</i> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <i>19</i> P.M. <i></i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE - <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL EXAMINER'S NAME (Type) <i>John G. Ball</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED
<i>March 24, 1969</i> | | |
| 23a. BURIAL CREMATION, (Type) <i>Burial</i> | | | 23b. DATE <i>3-27-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Elijah Church.,</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Poolesville, Md.</i> | |
| 24. FUNERAL DIRECTOR <i>Robert L. Snow</i> | | | ADDRESS <i>Rockville, Md.</i> | | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 28 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. Jones</i> |

04368

RECEIVED BY THE U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C. 20240

U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C. 20240

with the

(with the)

Professional

Survey

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04263

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04255

| | | | | | | | |
|--|---------------|--|--------|---|---|---|---|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 3 12 1969 | | 2b. HOUR
1 18 AM |
| Howard | | Smink | | Ynger | | | |
| 3. SEX
M. | 4. RACE
W. | 5. DATE OF BIRTH
Sept. 5/1905 | | 6. AGE (in years
last birthday)
63 YRS. | IF UNDER 1 YEAR
MONTHS | IF UNDER 24 HRS.
HOURS | 2c. DATE PRONOUNCED DEAD
Month March Day 12 Year 1969 |
| 70. BIRTHPLACE (State or foreign
country) Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery | | |
| 10. CITY OR TOWN OF DEATH
Bethesda. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
5939 Anniston Rd. | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
ESTIMATOR | | 12b. KIND OF BUSINESS OR
INDUSTRY
CONSTRUCTION |
| 130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN
Bethesda | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
5939 Anniston Rd. | |
| 14. FATHER'S NAME
First Middle Last
George Unger | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Clara Smink | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, or unknown) no | | 16b. SOCIAL SECURITY NO.
— | | 17. INFORMANT
Knight Funeral Home, Williamsport Penna. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4124 coronary Insufficiency Acute.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. } (b) cardio Vascular Disease -
DUE TO, OR AS A CONSEQUENCE OF
(c) years | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Sudden |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type) | | John S. Bell | | M.D. | | 22b. DATE SIGNED
March 12, 1969 | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
3-13-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
GREENLAWN MEMORIAL PARK | | 23d. LOCATION (City or Town) (County) (State)
CLINTON, LYCOMING CO, PENNA. | |
| 24. FUNERAL DIRECTOR
JOSEPH GAULER'S SONS, INC. | | ADDRESS
5130 WISC. AVE
N.W., WASH., D.C. | | 25a. REC'D BY REGISTRAR
DATE MAR 17 1969 | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--|
| 04264 | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | 04256 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) KEVIN LYNN VREDENBURG | | | | | 2a. DATE OF DEATH MARCH Month 28 Day 1969 Year | | | | | 2b. HOUR 530A M | | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH 6 AUGUST 1963 | | | 6. AGE (In years last birthday) 5 YRS. | | | IF UNDER 1 YEAR MONTHS 7 DAYS 23 | | IF UNDER 24 HRS. HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) CALIFORNIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH MONTGOMERY COUNTY Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A | | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY St. Marys | | | 13c. CITY OR TOWN LEXINGTON PK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER RT#2, BOX 107142 | | | | |
| 14. FATHER'S NAME First EUGENE K VREDENBURG Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First YOSHICA Middle IZUMI Last | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) TETRALOGY OF FALLOT | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | |
| (b) POST-OP RIGHT SUBCLAVIAN ARTY. TO PULMONARY | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF ARTY SHUNT | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 27MAR69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED TETRALOGY OF FALLOT | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 17 MARCH , 19 69 , to 28 MARCH , 19 69 , that XX (we) last saw the deceased alive on 28 MARCH , 19 69 , and that in XX (our) opinion death occurred on the date and hour and from the causes stated above XX (we) did XX view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE W. E. BEASLEY, M.D. | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) W. E. BEASLEY, M.D. | | | | | 22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE 4-1-69 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | | 23d. LOCATION (City or Town) Arlington (County) (State) Virginia | | | | | | | |
| 24. FUNERAL DIRECTOR 557 Wisconsin Ave., Bethesda, Md. | | | | | 25a. REC'D BY REGISTRAR APR 3 1969 DATE | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|---|---|---|---|--|--|--|--|
| 04265 | | CERTIFICATE OF DEATH | | | | | | 04257 | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Maria Antonieta Fortes WAGNER | | | | | 2a. DATE OF DEATH
Month Day Year
March 19 1969 | | | 2b. HOUR P
1120 M | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
March 26, 1912 | | 6. AGE (In years lost birthday)
56 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
Brazil | | 7b. CITIZEN OF WHAT COUNTRY?
Brazil | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE
S. Dakota | | | 13b. COUNTY
Codington | | 13c. CITY OR TOWN
Watertown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1403 West Kemp Avenue | |
| 14. FATHER'S NAME First Middle Last
Artur - Fortes | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Guilhermina - Alcantara | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) ---- | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT Watertown, South Dakota
Mr. Edmund G. Wagner, 1403 West Kempt Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma breast with widespread metastases
174X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar. 10 , 19 69 , to Mar. 19 , 19 69 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on Mar. 19 , 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Theodore H. Wilson, Jr. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED
March 20, 1969 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Theodore H. Wilson, Jr., M.D. | | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-24-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler Sons ADDRESS
5130 Wisconsin Ave., N. W. Washington, D. C. | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 26 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| 04266 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04258 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-------------------|--|--|--|--|--|--|--|--|--|-----------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Annette Jean WALLACE | | | | | | | | | | MARCH 8 1969 | | | | | | | | | | 5:15AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years lost birthday) | | | | | | | | | | IF UNDER 1 YEAR | | | | | | | | | | IF UNDER 24 HRS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FEMALE | | | | | | | | | | CAUC | | | | | | | | | | 8 APRIL 1921 | | | | | | | | | | 47 YRS. | | | | | | | | | | 11 MONTHS | | | | | | | | | | 11 DAYS | | | | | | | | | | HOURS | | | | | | | | | | MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WASHINGTON, D.C. | | | | | | | | | | UNITED STATES | | | | | | | | | | | | | | | | | | | | MONTGOMERY | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BETHESDA | | | | | | | | | | U. S. NAVAL HOSPITAL | | | | | | | | | | HOUSEWIFE | | | | | | | | | | NONE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. CITY OR TOWN | | | | | | | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MARYLAND | | | | | | | | | | MONTGOMERY | | | | | | | | | | OLNEY | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 3408 COLONIAL CT. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Clifton A. KOESTER | | | | | | | | | | RUTH A. WINDAS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NO | | | | | | | | | | 577-20-4229 | | | | | | | | | | John G. Wallace-3408 Colonial Court, Olney, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | Carcinoma of the breast with metastases | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 174X | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | (b) | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (H) (this hospital) attended the deceased from 26 FEB, 1969, to 8 MARCH, 1969, that (X) (we) last saw the deceased alive on 8 MARCH, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Robert C. Cochran, M. D. | | | | | | | | | | 10 MARCH 69 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Robert C. Cochran, M. D. | | | | | | | | | | Naval Hospital, Bethesda, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | March 11, 1969 | | | | | | | | | | Arlington National Cemetery Arlington Va. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Glen Carter | | | | | | | | | | MAR 14 1969 | | | | | | | | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Silver Spring, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

04366

REMARKS OF BIRTH

DATE OF BIRTH 8 APRIL 1941
PLACE OF BIRTH [illegible]
CITY [illegible]

STATE OF [illegible]
COUNTRY [illegible]

RELIGION [illegible]
MARRIAGE [illegible]

EDUCATION [illegible]
OCCUPATION [illegible]

REMARKS OF THE BIRTH [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04267

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04259

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) John Arthur Wallace | | | 2a. DATE OF DEATH
Month March Day 30 Year 1969 | | | 2b. HOUR 12:20 MIN PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
1 October 1912 | | 6. AGE (In years lost birthday)
56 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Owner | | 12b. KIND OF BUSINESS OR INDUSTRY
Vending Machine Co. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
West Virginia | | 13b. COUNTY
Oak Hill | | 13c. CITY OR TOWN
Oak Hill | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
401 Jones Avenue | |
| 14. FATHER'S NAME First Peter Middle I. Last Wallace | | | 15. MOTHER'S MAIDEN NAME First Maude Middle Nicholson Last Nicholson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) yes | | 16b. SOCIAL SECURITY NO.
1942-46 | | 17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland 20014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pseudomonas Septicemia
1538
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Bronchopneumonia (bilateral)
DUE TO, OR AS A CONSEQUENCE OF
(c) Adenocarcinoma of colon | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 Hours
48 Hours
2 Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that XX (this hospital) attended the deceased from 5 March , 19 69 , to 30 March , 19 69 , that XX (we) lost saw the deceased alive on 30 March 19 69 , and that in XX (our) opinion death occurred on the date and hour and from the causes stated above, XX (we) (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
William C. Wood MD | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
30 March 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type) William C. Wood, MD. | | | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
4-2-69 | | 23c. NAME OF CEMETERY OR CREMATORY
High Lawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Oak Hill W. Va. | | | |
| 24. FUNERAL DIRECTOR Francis J. Collins ADDRESS
500 Univ. Blvd. W. Silver Spring, Md. | | | | 25a. REC'D BY REGISTRAR
APR 3 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

7
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04268

04260

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|--|---|---|---|---|---|---|--|
| 1. DECEASED-NAME
(Type or print)
First Middle Last
Brian James Wandless | | | 2a. DATE OF DEATH
Month Day Year
March 23 1969 | | | 2b. HOUR
A M
2:10 | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
February 2, 1965 | | 6. AGE (In years
last birthday)
4 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country)
Washington, DC. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
The Clinical Center | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Child | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Virginia | | 13b. CITY OR TOWN
Arlington | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2844 South Buchanan Street | | | |
| 14. FATHER'S NAME
First Middle Last
James N. Wandless | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Carolyn (NMN) Boughner | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
The Medical Record Address
The Clinical Center, NIH, Bethesda, Md 20014 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
2040 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe proctitis
DUE TO, OR AS A CONSEQUENCE OF (c) Acute lymphocytic leukemia
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Hours Days 10 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that the (this hospital) attended the deceased from 15 March, 1969, to 23 March, 1969, that it (we) lost saw the deceased alive on 23 March 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, it (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Alan Snyder | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
March 23, 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Alan L. Snyder, M.D. | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md 20014 | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
3-27-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Doupin Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Doupin, Doupin Co. Pa. | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHERY | | 24b. ADDRESS
755 Wisconsin Ave.
Bethesda, Maryland | | 24c. REC'D BY REGISTRAR
MAR 26 1969 | | 24d. REGISTRAR'S SIGNATURE
Charles Judge | | | |

28520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|--|--|---|
| 300gms to weight 04269 | | | | | CERTIFICATE OF DEATH | | | | | 04261 | |
| 1. DECEASED-NAME
(Type or print) INFANT | | | | | 2a. DATE OF DEATH
Month 3 Day 7 Year 69 | | | | | 2b. HOUR
530 M | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
3/7/69 | | | 6. AGE (In years last birthday)
YRS. — | | IF UNDER 1 YEAR
MONTHS — DAYS — | | IF UNDER 24 HRS.
HOURS — MIN — |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SUBURBAN HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
— | | | 12b. KIND OF BUSINESS OR INDUSTRY
— | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
DERWOOD | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
19813 MUNCASTER Rd. | | |
| 14. FATHER'S NAME
First GEORGE Middle EARL Last WARD | | | 15. MOTHER'S MAIDEN NAME
First MARION Middle ELAINE Last NICHOLS | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown — (If yes give war or dates of service) — | | | 16b. SOCIAL SECURITY NO.
— | | 17. INFORMANT
MOTHER | | | Address
SAME | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
777X IMMEDIATE CAUSE (a) Immaturity
DUE TO, OR AS A CONSEQUENCE OF
(b) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. —
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
— | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
— | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/7 , 19 69 , to 3/7 , 19 69 , that (I) (we) last saw the deceased alive on 3/7 , 19 69 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
C. B. Brang | | | 22c. DATE SIGNED
7 Mar 69 | | | 22d. PHYSICIAN'S NAME (Type)
— | | | 22e. ADDRESS
— | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
3/18/69 | | 23c. NAME OF CEMETERY OR CREMATORY
SUBURBAN HOSPITAL | | 23d. LOCATION (City or Town) (County) (State)
Bethesda Montg. Md. | | 23e. REC'D BY REGISTRAR
— | | |
| 24. FUNERAL DIRECTOR
RS. Amelia C. Carter, Administrator | | | 24b. ADDRESS
— | | | 25a. REGISTRAR'S SIGNATURE
— | | | 25b. REGISTRAR'S SIGNATURE
— | | |
| DATE MAR 24 1969 | | | | | | | | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04270

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04262

| | | | | | | | | | | | |
|---|---------|------------------|--|--|------------------------------------|--|-----|--|-----------------------------------|--|-----------------------|
| 1. DECEASED NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year | | | | 2b. HOUR | |
| Camille | | | EGNER | | | Washburn | | | | 10 ¹⁵ P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Fe. | W. | Dec 18 1896 | 72 YRS. | MONTHS | DAYS | HOURS | MIN | March | Day | Year | 10 ¹⁵ P.M. |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Missouri | | | U.S.A. | | | | | | Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | Suburban | | | HOUSEWIFE | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | Montgomery | | | Kensington | | YES | | 10100 Hadley Place | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| William Frederick Egner | | | Beryl Mansfield Fish | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| | | | 161-36-1796 | | | MRS ALBERT E. BEITZEL, SISTER | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cerebral Hemorrhage Massive.</u>
4124
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Cardio Vascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18 hr
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | March 2, 1969 | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) Md. | | | |
| Burial | | | 3-5-1969 | | Cedar Hill Cemetery | | | Suitland, Prince Georges Count | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. Washington, D.C., 20016 | | | | | | MAR 10 1969 | | Charles Judge | | | |

04330

WORLD WIDE RECORDS COMPANY

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WORLD WIDE RECORDS COMPANY

WORLD WIDE RECORDS COMPANY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|--|---|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 04271 | | | | | | | | | | |
| 04263 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| RACHEL | | | H. WATKINS | | | March Month 20 Day 1969 Year | | 4:30 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | |
| Female | | White | | Feb. 28, 1891 | | 78 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Wisconsin | | USA | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Rockville | | | residence | | | Housewife | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Montgomery | | Rockville | | YES | | 107 W. Jefferson St. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Unknown | | | Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | | | | Maryland 20906 | | | | | |
| | | | | | Hanson Watkins-3227 BelPre Rd. Silver Spring | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CORONARY THROMBOSIS | | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) GENERALIZED ARTERIOSCLEROSIS | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) CORONARY ARTERY DISEASE | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| Nephrosclerosis | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 13, 1969, to MARCH 20, 1969, that (I) (we) last saw the deceased alive on MARCH 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | |
| Gordon S. Rosenberger | | MARCH 20, 1969 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | |
| Gordon S. Rosenberger | | 310 WEST MONTGOMERY AVE ROCKVILLE, MARYLAND | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 3/24/69 | | Arlington National | | Arlington, Virginia | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md. | | MAR 26 1969 | | Charles Judge | | | | | | |

17340

Summary

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Abstract

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(continued)

04272

CERTIFICATE OF DEATH

04264

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) ELLIS | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year March 24 1969 | | | 2b. HOUR
940 A.M. | | |
| 3. SEX
m | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
12-9-99 | | | 6. AGE (In years last birthday)
69 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
VA. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING, MD. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLY CROSS Hosp | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Pressman | | | 12b. KIND OF BUSINESS OR INDUSTRY
Printing | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | | 13b. COUNTY
MONTGOMERY | | | 13c. CITY OR TOWN
WHEATON | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
12203 LIVINGSTON ST. | | | 14. FATHER'S NAME
First Middle Last
Acree Weakley | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Elizabeth Broyles | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | | |
| 16b. SOCIAL SECURITY NO.
214-03-8333A | | | 17. INFORMANT
Address
Ethel B. Weakley-12203 Livingston St., Md. Wheaton | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction posterior wall, left ventricle.
DUE TO, OR AS A CONSEQUENCE OF
(b) Thrombotic occlusion, right coronary artery.
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerotic heart disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1960 , to MARCH 24, 1969 , that (I) (we) last saw the deceased alive on MARCH 24 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Edward A. Beeman M.D. DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
MARCH 24, 1969 | | |
| 22d. PHYSICIAN'S NAME (Type)
EDWARD A. BEEMAN | | | | | | 22e. ADDRESS
1015 SPRING ST. SILVER SPRING MD 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
March 27, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY
Burtonsville Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Spencerville, Maryland | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. Silver Spring, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 28 1969 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

arteriosclerotic heart disease.
Thrombotic occlusion, right coronary
artery.
acute myocardial infarction posterior
wall, left ventricle.

257 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--------------|--|--|--|--|---|--|---|--|--|--|--|--|--|--|-----------------|--|---------------------|--|--|--|-------|--|--|--|
| 04273 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 04265 | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
ELIZABETH DEANDORF WEAVER | | | | | | | | | | | | 2a. DATE OF DEATH
Mar Month 10 Day 1969 Year | | | | | | | | 2b. HOUR
8:25P M | | | | | | | |
| 3. SEX
F | | | 4. RACE
W | | | 5. DATE OF BIRTH
MAY 18, 1890 | | | | 6. AGE (In years lost birthday)
78 YRS. 9 22 | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | | IF UNDER 24 HRS | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
US | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
GARRETT PARK | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
4509 Oxford St | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE
Md. | | | | 13b. COUNTY
Montg | | | | 13c. CITY OR TOWN
GARRETT PARK | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
4509 Oxford St. | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Jasmon Fremont Defandorf | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Harriet Holmes | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | | | | 16b. SOCIAL SECURITY NO.
217-46-7000 | | | | | | 17. INFORMANT Charles R. Weaver Address
6922-Woodside Pl., Chevy Chase, Md. | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cardio-vascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 months
8-10 years | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>43</u> , to <u>March 10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Katharine A. Chapman, M.D. | | | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
March 10, 1969 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Katharine A. Chapman | | | | | | | | | | | | 22e. ADDRESS
3924 Baltimore St.
Kensington, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, OR OTHER (Specify)
Burial | | | | 23b. DATE
3-11-69 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | | | 23d. LOCATION (City or Town) (County) (State)
Suitland Maryland | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS
7557-Wisconsin Ave., Bethesda, Md. | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
MAR 14 1969 DATE | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

06373

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

Very respectfully,
Sincerely,
Very truly yours,
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04274

04266

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
William Gerald Wilkes | | | 2a. DATE OF DEATH
Month Day Year
March 26 1969 | | | 2b. HOUR
12 ³⁰ PM | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
1-28-76 | | 6. AGE (in years last birthday)
93 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington Sanitarium & Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired Pressman | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Prince Georges | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
6415 Knollbrook Drive | |
| 14. FATHER'S NAME First Middle Last
Gerald Wilkes | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Margaret Allen Hoke | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
Yes (no, or unknown) | | 16b. SOCIAL SECURITY NO.
577-30-6712 | | 17. INFORMANT
Records - Washington Sanitarium & Hospital | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac failure</u>
402X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive heart disease & A.V. Block & failure</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dronabin</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>acute</u>
<u>2 days</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY
(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1967, to Mar 26 1969, that (II) (we) lost saw the deceased alive on March 26 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Ernest A. Sarao | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/26/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
ERNEST A. SARAO M.D. | | | | 22e. ADDRESS
7006 New Hampshire Ave Takoma Park Md | | | | | |
| 23a. BURIAL, CREMATION, REBURY
Burial | | 23b. DATE
3/29/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Wash. Nat. Cem. | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Md. | | | |
| 24. FUNERAL DIRECTOR
Halley's Funeral Home Inc. | | | | ADDRESS
Mt. Rainier Maryland | | 25a. REC'D BY REGISTRAR
APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Underwood | |

04374

CERTIFICATE OF DEATH

| | | | | | |
|------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased | | Date of Birth | | Sex | |
| John Doe | | 1925 | | Male | |
| Place of Birth | | Date of Death | | Cause of Death | |
| New York | | 1985 | | Heart Disease | |
| Occupation | | Residence | | Burial Place | |
| Teacher | | 123 Main St | | Cemetery | |
| Signature of Physician | | Signature of Registrar | | Signature of Witness | |
| [Signature] | | [Signature] | | [Signature] | |
| Date of Certificate | | Issued by | | Official Seal | |
| 1985 | | John Doe | | [Seal] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1-69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--------------------------|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Walter L. Wilkins | | | | | | 3 Month 31 Day 69 Year | | 5:45 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Male | | White | | January 21, 1894 | | 75 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Washington, D.C. | | U.S.A. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | Carriage Hill Nursing Home | | Ret. Treasurer-Fairfax Distb. Co. | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Montgomery | | Silver Spring | | | | 1607 South Springwood Dr. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| John L. Wilkins | | | Catherine M. Dieste | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| Yes | | 602 1917-1919 577-07-9812 | | Mrs. Louise A. Emmell-1903 | | S.S., Md. | | East West Hwy | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Prothrombin Defect</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Posttraumatic Heart Disease</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| <u>Cerebral Hemorrhage 10-30-68</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 31, 1969</u> , to <u>March 31, 1969</u> , that (I) (we) last saw the deceased alive on <u>3-22-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| <u>Samuel T. Kimble M.D.</u> | | 3-31-69 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| Seruch J. Kimble | | 9801 Georgia Ave, Silver Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | April 3, 1969 | | Gate of Heaven Cemetery | | Silver Spring, Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR | | 24b. ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Warner E. Pumphrey, Inc. | | 8434 Georgia Avenue Silver Spring, Md. | | DATE APR 7 1969 | | J. Charles Judge | | | |

04372

MINISTRY OF DEFENSE

MINISTRY OF DEFENSE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--------------------------|--|--|--|--|---------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04276 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Gene Austin Williams | | | | | | Month Day Year | | 12:30 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | |
| Male | | White | | 29 July 1937 | | 31 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 10. MONTH | |
| Virginia | | U.S.A. | | | | Montgomery | | Md. | |
| 11. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | The Clinical Center, NIH | | Reporter | | Publishing Co. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Virginia | | Warren | | Front Royal | | | | 423 Duncan Avenue | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Aylor G. Williams | | | Neville | | | North | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| | | | 223-46-3915 | | The Medical Record Address | | | | |
| | | | | | The Clinical Center, NIH, Bethesda, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiac Arrest during surgery</u> | | | | | | | | | |
| 2252 | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) <u>Brain Tumor, Right Frontal, probable meningioma</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| <u>Hodgkin's Disease - clinically in remission</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 3/25/69 | | Brain tumor | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>11 March</u> , 19 <u>69</u> , to <u>25 March</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>25 March</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | | |
| <u>Robert E. Curran</u> | | | | 25 March 1969 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| Robert E. Curran, M.D. | | | | The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3/28/69 | | Willis Chapel Cemetery | | Rappahannock Co. Virginia | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robertshaw*Turner Front Royal, Virginia | | | | DATE APR 1 1969 | | | | | |

04830

STATE OF TEXAS

IN THE COUNTY OF DALLAS

1904

04277

CERTIFICATE OF DEATH

04269

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) Norman Lansdale Williams | | | 2a. DATE OF DEATH
Month March Day 4 Year 1969 | | | 2b. HOUR 4:45 P M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
June 6, 1894 | | 6. AGE (In years last birthday)
74 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 IF UNDER 24 HRS.
HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Montgomery Gen. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY
Farming | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Germantown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Rt. 1, Box 110 | |
| 14. FATHER'S NAME First Middle Last
Joseph Williams | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Sophonria Anderson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
215-32-2576 | | 17. INFORMANT Address
Mrs Hilda M. Williams, Germantown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Advanced Arteriosclerotic Cardiovascular Disease
4122 DUE TO, OR AS A CONSEQUENCE OF with Hypertension.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Terminal Pneumonitis | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
-- | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
-- | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)
No Injury | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1935 , 19____, to March 4, 1969 , that (I) (we) lost saw the deceased alive on March 4, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>M. McKendree Boyer</i> | | | | DEGREE
M. D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
March 5, 1969 | |
| 22d. PHYSICIAN'S NAME (Type) M. McKendree Boyer | | | | 22e. ADDRESS 9701 Church Street Damascus, Maryland. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
March 7, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Salem Meth. | | 23d. LOCATION (City or Town) (County) (State)
Cedar Grove, Md. | | | |
| 24. FUNERAL DIRECTOR
Olin L. Molesworth, Damascus, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAR 7 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

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• *Journal of Management Education* 23(1): 10-19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04278

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04270

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|--|--------------------------|---|---|------------------------|--|--|------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR P | | |
| Sibyl | | | Alexia | Williams | March 21 1969 | | | 10:05 M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | Negro | | 2 January 1956 | | 13 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Pennsylvania | | USA | | | | Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | The Clinical Center, NIH | | | Student | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Pennsylvania | | | | | Harrisburg | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 605 North 15th Street | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Glenn | | | E. | Williams, Jr. | Elizabeth | R. | | | Russell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT The Medical Record Address | | | | |
| No | | | | | None | | The Clinical Center, NIH, Bethesda, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple cardiac arrests | | | | | | | | | | 3 hours | |
| 2500 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) Diabetic ketoacidosis | | | | | | | | | | 12 hours | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| Acute lymphocytic leukemia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town County State | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Feb. 12, 1969, to March 21, 1969, that (X) (we) last saw the deceased alive on March 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert B Livingston MD DEGREE | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 22 March 1969 | | |
| 22d. PHYSICIAN'S NAME (Type) Robert B. Livingston, M.D. | | | | | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 3-25-1969 | | Wm Howard Day Cemetery | | | Steelton, Pa. | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR DATE APR 7 1969 | | | | | | | | | |
| Melvin Hooper - 1416 Cumberland St. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | |

8061

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| 04279 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04271 | |
|---|--|---|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
<i>Mildred E. Wilson</i> | | | 2a. DATE OF DEATH
Month Day Year
<i>3-26-69</i> | | | 2b. HOUR
<i>4:25 PM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>12-21-27</i> | | 6. AGE (In years last birthday)
<i>41</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>Clerk Typist</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived or admission) STATE
<i>Md.</i> | | 13b. NAME OF INSTITUTION: Residence before
<i>Home George Hyattsville</i> | | 13c. CITY OR TOWN
<i>Hyattsville</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>6806 Highview Terrace</i> | | 14. FATHER'S NAME First Middle Last
<i>JOSEPH GROVES</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Ellen BLADEN</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>57234-7515</i> | | 17. INFORMANT
<i>ANDREW K. WILSON</i> | | Address
<i>SAME AS #13</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cirrhosis, liver, Laennec's, advanced</i>
<i>571.0</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>6 yrs.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>None</i> | | | | | | | |
| 19a. DATE OF OPERATION
<i>NA</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>NA</i> | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>NO</i> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
<i>19</i> P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11:31</i> , 19 <i>69</i> , to <i>3:28</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/26</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Edgar H. Levin</i> | | 22c. DATE SIGNED
<i>3/27/69</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>EDGAR H. LEVIN</i> | | | |
| 22e. ADDRESS
<i>8218 Wisconsin Ave Bethesda</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>3-29-1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>ROCK CREEK CEM</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>WASHINGTON, D.C.</i> | |
| 24. FUNERAL DIRECTOR
<i>W.W. CHAMBERS</i> | | ADDRESS
<i>60 RIVERDALE, MD</i> | | 25a. REC'D BY REGISTRAR
<i>DA APR 1 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 411 Maryland State Department of Health
4-3-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04280

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04272

| | | | | | | | |
|---|------------------|---|--------|---|---|---|---|
| 1. DECEASED NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 3-23-1969 | | 2b. HOUR
3:05 |
| JAMES | | Henry | | WISER | | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
7-22-97 | | 6. AGE (In years
last birthday)
71 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
22 | 2c. DATE PRONOUNCED DEAD
Month 3 Day 23 Year 19 69 | |
| 7a. BIRTHPLACE (State or foreign
country) Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Wash. San. & Hosp. | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Carpenter | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN
T.P. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
6806 Laurel St. | | 14. FATHER'S NAME
First Middle Last
Harry Bartley | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Mary Nash | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
NO | | 16b. SOCIAL SECURITY NO.
--? | | 17. INFORMANT
Peters Funeral Home Gettysburg, Penn. | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute rt. coronary thrombosis
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type) | | Belden R. Reap M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
3/23/1969 | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
3-26-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Fairview Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Mercersburg, Penn. | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey Inc. 8434 Ga. Ave. Spring, Md. | | | | 25a. REC'D BY REGISTRAR
MAR 28 1969 | | 25b. REGISTRAR'S SIGNATURE
J. C. ... | |

07540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
30M REV. 1/68

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 04281 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04273 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | |
| Ronald Joseph Wisniewski | | | | | | Month | Day |
| | | | | | | March | 8 |
| | | | | | | Year | 1969 |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | |
| Male | | | White | | 5 March 1962 | 7 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH |
| Virginia | | | USA | | | | Montgomery Md. |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| Bethesda | | | The Clinical Center, NIH | | | Student | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER |
| Virginia | | | Fairfax | | Springfield | | 6711 Jerome Street |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | |
| Louis R. Wisniewski | | | | | | Anna Sitko | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| No | | | None | | The Medical Record Address | | |
| | | | | | The Clinical Center, NIH, Bethesda, Maryland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> | | | | | | | 1 hour |
| 746.4 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| (b) <u>Operative repair-atrial septal defect</u> | | | | | | | 4 hours |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) <u>Congenital heart disease</u> | | | | | | | 7 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| Cerebral edema | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 3/7/69 | | Atrial Septal Defect | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>2 March</u> , 19 <u>69</u> , to <u>8 March</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>8 March</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | |
| <u>Edward Jacobs, Jr. MD</u> | | | | | | March 8 1969 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | |
| Edward Jacobs, Jr., M.D. | | | | | | The Clinical Center, National Institutes of Health, Bethesda, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 3/11/1969 | | M.O.C. Cemetery | | Mt. Carmel Pennsylvania | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| 1331 Rockville Pike Tyson Wheeler Funeral Home Rockville, Md. | | | | DATE MAR 12 1969 | | <u>William J. Young</u> | |

18546

DATE: 10/1/88

Impr. 10. 1788

1114

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|------------------------------|--|---|-------------------------------|--|--|--|--|
| <div>04282</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>04274</div> | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | | 2b. HOUR |
| NORMAN H. WOLFE | | | | | | 3-21 1969 | | | 145 M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year | | | 2d. HOUR |
| M | Cauc | 7-4-181 | 87 YRS. | | | 3 21 1969 | | | 140 M |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. |
| Md. | | U.S.A. | | | | Montgomery | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Cherry Chase | | | 9015 Jones Mill Rd. | | | Retired | | | Farming |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| Md | | | Montgomery | | | Cherry Chase | | | 9015 Jones Mill Rd. |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Jesse Wolfe | | | Laura Hyatt | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| no | | | | | | Mary H. Kirtland (SAME) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gunshot wound in</u>
<u>955X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Heal with Exsanguination</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Depression — Senility</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR MIN. <u>11:00 P.M.</u> <u>3-21 1969</u> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<u>Deceased depressed, shot self with shotgun</u> | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
<u>Rear of home</u> | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
<u>9015 Jones Mill Rd. Cherry Chase Montg. Md.</u> | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| 22b. DATE SIGNED | | | 22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| ACTUAL SIGNATURE | | | ADDRESS (Street, city, town or county) | | | | | | |
| Belden R. Read M.D. | | | MARCH 21, 1969 | | | | | | |
| EXAMINER'S NAME (Type) | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | |
| Belden R. Read M.D. | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) |
| | | | 3/24/69 | | | Monacacy | | | Beallsville Montg. Md. |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE |
| Constance C. Hilton Barneville Tpd. | | | | | | MAR 28 1969 | | | 10 Clonellan Wedge |

04888

1970-07-23

1970-07-23

1970-07-23

1970-07-23

1970-07-23

1970-07-23

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| 04283 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04275 | |
|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) JOANN GATES WOODSON | | | | 2a. DATE OF DEATH
Month March Day 04 Year 1969 | | 2b. HOUR
10:30 AM | |
| 3. SEX
FEMALE | | 4. RACE
CAUC | | 5. DATE OF BIRTH
14 DEC. 1920 | | 6. AGE (In years last birthday)
48 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
WASH. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
NAVAL HOSPITAL, BETHESDA | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
VIRGINIA | | 13b. COUNTY
FAIRFAX | | 13c. CITY OR TOWN
LORTON | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
10608 BELMONT BLVD. | | 14. FATHER'S NAME
First ROSS S. Middle WILSON Last ROSS S. WILSON | | 15. MOTHER'S MAIDEN NAME
First MAURINE Middle GATES Last MAURINE GATES | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
UNKNOWN | | 17. INFORMANT
WALTER B. WOODSON | | Address
10608 BELMONT BLVD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Melanoma with generalized metastases
1729 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (A) (this hospital) attended the deceased from 6 FEB , 19 69 , to 4 MARCH , 19 69 , that (A) (we) last saw the deceased alive on 4 MARCH , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
E. Diamond, M.D. | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5 MARCH 1969 | |
| 22d. PHYSICIAN'S NAME (Type)
E. DIAMOND, M.D. | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Maryland | | | |
| 23a. BURIAL CREMATION
CREMATION | | 23b. DATE
3/6/1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION (City or Town) (County) (State)
Washington, D C | |
| 24. FUNERAL DIRECTOR
DEMAINE FUNERAL HOME | | | | ADDRESS
ALEXANDRIA, VA. | | 25a. REC'D BY REGISTRAR
DATE MAR 10 1969 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04284

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04276

| | | | | | | | | | |
|---|---------------------|---|--|--|--|--|--|--|-------------------------|
| 1. DECEASED-NAME (Type or Print) <i>Myrtle Esther Wright</i> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>3</i> Day <i>2</i> Year <i>1969</i> | | | 2b. HOUR <i>8:45</i> M. | | | |
| 3. SEX <i>Fe</i> | 4. RACE <i>Cauc</i> | 5. DATE OF BIRTH <i>July 21, 1878</i> | 6. AGE (In years (no birthday)) <i>90</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD <i>3-2</i> Day Year <i>1969</i> | 2d. HOUR <i>8:45</i> M. |
| 7a. BIRTHPLACE (State or foreign country) <i>Ohio</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>2903 Newton St.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Silver Spring</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>2903 Newton St. Silver Spring, Md.</i> | |
| 14. FATHER'S NAME First <i>Brinton B. Hoopes</i> Middle <i></i> Last <i></i> | | | 15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Moore</i> Last <i></i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>177 22 2710</i> | | 17. INFORMANT <i>A Vera Weston</i> ADDRESS <i>2903 Newton St. Silver Spring, Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4123 Acute Coronary Insufficiency</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i></i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i></i> | | | | | | | | | |
| 19a. DATE OF OPERATION <i></i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i></i> | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i> | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i></i> | | 21f. LOCATION Street or R.F.D. No. <i></i> | | City or Town <i></i> | | State <i></i> | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>Belden R. Reap</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED <i>MARCH 3, 1969</i> | | | |
| EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) <i>2903 Newton St. Silver Spring, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>Mar 4, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill</i> | | 23d. LOCATION (City or Town) <i>Lansdale, Penn.</i> | | (County) <i></i> (State) <i></i> | |
| 24. FUNERAL DIRECTOR <i>Paul J. Smith Warner E. Pumphrey Inc.</i> | | | | ADDRESS <i>8434 Ga. Ave. Silver Spring, Md.</i> | | 25a. REC'D BY REGISTRAR <i>MAR 4 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>Judge</i> | |

FOR STATE
HEALTH DEPT.

04384

LEGAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK
COUNTY OF ALBANY

| | | | |
|-----------------------|--|------------------------|--|
| Name of Deceased | | Date of Death | |
| John Doe | | July 10, 1978 | |
| Age | | 35 | |
| Sex | | Male | |
| Race | | White | |
| Marital Status | | Single | |
| Occupation | | Student | |
| Cause of Death | | Sudden | |
| Place of Death | | Home | |
| Signature of Examiner | | Signature of Physician | |
| [Signature] | | [Signature] | |
| Date of Certificate | | Date of Death | |
| July 10, 1978 | | July 10, 1978 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04285 | | | | | 04277 | | | | |
| Item 5 Film 410 3/13/69 kk | | | | | CERTIFICATE OF DEATH | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Grace A Zemke</i> | | | | | 2a. DATE OF DEATH
Month <i>March</i> Day <i>4</i> Year <i>1969</i> | | | 2b. HOUR
<i>11:15</i> M | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>3/21/1916</i> | | 6. AGE (In years last birthday)
<i>74</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
<i>CANADA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Retired</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i> | | 13b. COUNTY
<i>Mont</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>199 Collins Ave -</i> | |
| 14. FATHER'S NAME First <i>ROBERT</i> Middle <i>Laidlaw</i> Last <i>Laidlaw</i> | | | | | 15. MOTHER'S MAIDEN NAME First <i>CLARA</i> Middle <i>Armington</i> Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
<i>382-20-7210</i> | | 17. INFORMANT
<i>Robert W. Zemke</i> <i>7029 Stearns St. Long Beach, Cal.</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma of Bowel, metastatic</i>
<i>1539</i>
DUE TO, OR AS A CONSEQUENCE OF
<i>to liver</i>
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.
(b)
(c)
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 weeks</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/27, 1969</i> to <i>THE PRESENT</i> that (I) (we) last saw the deceased alive on <i>MARCH 3 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Edward W. Youngblood</i> | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>March 4, 1969</i> | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>EDWARD W. YOUNGBLOOD</i> | | | | | 22e. ADDRESS
<i>WASHINGTON CLINIC, WASH, D.C.</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Cremation</i> | | 23b. DATE
<i>3/4/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Prince George Co., Md.</i> | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 11 1969</i> | |
| 24. FUNERAL DIRECTOR
<i>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</i> | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Richard Judge</i> | | | | |

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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Rockville, Md.